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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Nepal

The Executive Director recommends that the Executive Board approve the country programme of Nepal for the period 1992-1996 in the amount of $25 million from general resources, subject to the availability of funds, and $34,620,000 in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. Nepal is one of the poorest countries in the world. Its per capita gross national product (GNP) of $180 reflects the relative wealth of Kathmandu, the capital. However, according to recent estimates, 70 per cent of the country's total population live in absolute poverty. According to the 1991 census, the infant mortality rate (IMR) and the under-five mortality rate (U5MR) are 107 and 165 per 1,000 live births, respectively; and 65 per cent of the adult population is illiterate, with a female illiteracy rate of 82 per cent. It is estimated that 50 per cent of children under five years of age suffer from severe or moderate malnutrition. The maternal mortality rate (MMR) is estimated to be 850 per 100,000 live births, one of the highest in the world.

2. Many of Nepal's poor are engaged in subsistence farming. A typical poor hill farming family has seven members and owns about a half hectare of land, which produces enough to feed the family for between three and six months of the year. During a substantial part of the year they eat only one meal per day. In such a family there is continuing malnutrition and illness, and it is almost certain that at least one child will die.

3. In Nepal, 70 per cent of all production is used to meet basic livelihood needs and does not involve the cash economy. Children provide an important source of labour from an early age. A child in the 6- to-14-year age-group works from three to six hours per day and girls work twice as many hours as boys. Women spend 25 per cent more time than men on subsistence activities, in addition to their domestic work. Some 16 per cent of all human labour is devoted to fuel and fodder collection alone, in addition to water carrying. These chores are done by women and children, in addition to their farming and grazing work. In many cases, a family's food supply is insufficient to meet its nutrional needs, especially during the pre-harvest months. This situation is exacerbated by the fact that most women in Nepal are either pregnant or nursing during much of their short lives. Although the law sets the minimum age for marriage at 16, studies suggest that 22 per cent of girls are married by 13 years of age and 50 per cent by age of 16 years. Nepal is one of only three countries in the world where a woman's life expectancy is lower than a man's.

4. Nepal's population, currently estimated at 18.4 million, is growing at an annual rate of 2.6 per cent. Some 93 per cent of the labour force is engaged in agriculture. At current population growth rates, there will be some 300,000 new entrants per year into the labour force at the turn of the century. Some unexploited agricultural land remains.

5. In 1990, Nepal underwent a revolution and the Government became responsible to the people in a multi-party democracy. A new constitution guaranteeing basic freedoms is in place and a parliament was elected for the first time in 30 years. Previously undiscussed issues are now openly debated. In this more open atmosphere, initiatives such as the World Summit for Children have made it possible to increase advocacy for children in all

possible forms and at the highest political levels with the Government, non-governmental organizations (NGOs), professional associations, popular groups at the village level and the private sector.

PROGRAMME COOPERATION, 1988-1991

6. The country programme for 1988-1992 has been reduced to four years because the annual programme budget levels were increased and the approved funds disbursed ahead of schedule. The Government, with UNICEF cooperation, implemented the country programme with the objectives of reducing IMR, U5MR, illiteracy and malnutrition, increasing the accessibility of water supplies and improving sanitary conditions.

Health and nutrition

7. Nepal has a poor peripheral health care delivery system. Most of the 675 health posts face shortages of personnel, finances and essential drugs. UNICEF assisted the primary health care (PHC) system through the training of out-posted staff and the provision of essential drugs. UNICEF has joined other donors in supporting the training of 3,000 (out of 6,000) traditional birth attendants (TBAs), 25,000 community health volunteers and 4,000 village health workers (VHWs), all of whom help to link the community with the extended network of health posts. This strategy of strengthening the health support network through community involvement will continue to be emphasized in the new programme.

8. From a base in 1988 of less than 25 per cent coverage for most antigens, at the end of 1990 the Ministry of Health reported coverage figures that were close to 80 per cent. Some important activities contributing to the success of the expanded programme on immunization (EPI) effort were the development of the cold-chain infrastructure in all 75 districts, the supply of vaccines and equipment, the training of all 4,000 VHWs as vaccinators and of other central and field health staff in microplanning and mapping, and nationwide social mobilization activities.

9. For the control of diarrhoeal diseases (CDD), a communications effort promoted public awareness of the seriousness of diarrhoea and the importance of the use of oral rehydration salts (ORS)/salt-sugar solution. Some 65 per cent of mothers interviewed in a survey knew about ORS, but only 6 per cent knew about its correct preparation and use. Activities supported by UNICEF included training of personnel and the establishment of 200 oral rehydration therapy (ORT) corners in health facilities. National ORS production capacity doubled from 3.5 million to 7 million one-litre packets per year. CDD project activities were coordinated with the EPI, breast-feeding promotion, health education and water supply and sanitation activities.

10. UNICEF supported two pilot studies on acute respiratory infections (ARI) and on the administration of antibiotics by trained lay workers. This led to the adoption of a national policy to introduce an ARI-control programme nationwide, with the selective use of antibiotics for case management at the health-post level and below.

11. Except for a 1975 national nutrition survey, there are no updated national figures on child malnutrition. Survey samples taken later using the anthropometric methods of the 1975 survey showed slightly decreased malnutrition levels, but because of the differences in the age-groups studied, the figures are not strictly comparable. The trends for chronic malnutrition showed a decline from 48.2 per cent in 1975 to 42.8 per cent in 1982 and 35.2 per cent in 1987 (using the height-for-age criterion). In contrast, the severest form of malnutrition increased in number in the Far West, Central and the Hills districts. Until the end of 1990, UNICEF continued to support a broad-based multisectoral nutrition intervention project under the UNICEF/World Health Organization (WHO) joint nutrition support programme.

12. Breast-feeding promotion and education about weaning foods were incorporated into programmes to reach the rural poor, including a project on production credit for rural women, the small farmers development programme and formal and non-formal education. Some 90 per cent of women breast-feed their infants for six months. The adoption of the International Code of Marketing of Breast Milk Substitutes is expected to help prevent any future deterioration of this situation.

13. UNICEF continued to support the programme to control iodine deficiency disorders (IDD). According to available data, it achieved 95 per cent coverage of the 14- to 45-year age-group in the 33 districts where iodine deficiency is endemic. According to a 1985 impact evaluation study conducted by UNICEF and the Ministry of Health, this resulted in a significant drop in the incidence of goitre from 57.6 per cent in 1982 to 39.7 per cent in 1985, and in cretinism from 2.8 per cent to 0.4 per cent.

14. UNICEF supported vitamin A distribution which served 90 per cent of the target population in seven districts. UNICEF also supported a randomized community trial on 28,630 children aged 6 to 72 months, which showed that vitamin A supplementation produced a 30 per cent reduction in child mortality, compared with a similar unsupplemented control group.

Education

15. New approaches to non-formal education were part of the pilot education for rural development project in the Seti zone, which was supported by UNICEF, the United Nations Development Programme (UNDP) and the United Nations Educational, Scientific and Cultural Organization (UNESCO). Among these new approaches were the development of school clusters and educational resource centres, community involvement in education and school management, alternative education for out-of-school children (such as the Cheli Beti programme for out-of-school girls) and adult literacy. These efforts have benefited some

11,000 out-of-school girls (against the planned 66,000), and 23,000 adults (out of the 40,000 originally planned) in one of the most disadvantaged areas of the country.

16. The primary education project, supported jointly by the World Bank and UNICEF, addressed curriculum reform and development, which led to the testing and adaptation of relevant new curricula based on educational goals and learning objectives. Some of the experiences gained from the Seti zone project were developed further and applied on a wider scale in the primary education project. These included the development of adult literacy curricula, training modules and low-cost teaching materials, as well as the expansion of the Cheli Beti programme for out-of-school girls and the coeducational Shishkya Sadan project for out-of-school children. These non-formal educational activities have benefited more than 200,000 adults and out-of-school children, as opposed to the 140,000 originally planned. A 1990 evaluation indicated that 75.5 per cent of the participants in the literacy programme were young females and that 50 per cent had fully achieved literacy skills, while 25 per cent had achieved semi-literacy. The literacy programme efficiency ratio, as reflected in the completion rate, is 58 per cent. The per capita participant cost is $8.00. More than 50 per cent of the participants have used literacy and functional skills in their daily life activities. Adult participants have reported improvements in income, in the use of safe drinking water and sanitation, in immunization rates and in the number of visits to health posts. In developing its Education Master Plan for the period 1990-2001, the Ministry of Education drew on the experiences and approaches developed in the Seti zone and the primary education projects. The plan now provides the framework for national action in basic and primary education and for international support for those areas.

Water supply and sanitation

17. UNICEF has been one of the main donors supporting rural water supply and sanitation activities throughout the country. Approximately 810,000 people were given access to potable water, and sanitary latrines were built by 40,000 families. These figures were 40 per cent below expectations, however. Some problems encountered were frequent rotation of government staff; overly ambitious targets, especially for sanitation; insufficient area focus for UNICEF support; and delays in the release of funds to implementing levels.

18. UNICEF supported the training of more than 1,000 government staff of various levels and 20,000 community volunteers and users' committee members on water supply management, environmental sanitation and health education. A women's involvement component was developed within the sanitation campaign, benefiting 300,000 people (out of 500,000 planned). That approach is expected to be reflected in the forthcoming government policy on sanitation.

Convergent services

19. The area-based approach was used to deliver integrated basic services through revolving credit and poverty alleviation activities under the small-scale farmer development programme, serving 122,000 families, and the production credit for rural women project, serving 250,000 women. The income generated from the project activities was used to meet basic family needs; food had the highest priority, followed by health and educational needs. In one study, more than half of the women respondents indicated that there had been a positive change in the way they were treated by their families, friends and the community. Involvement in the credit project has increased women's participation in decision-making at home.

20. The 1989 impact evaluation study of the credit project indicated a loan repayment rate of about 88 per cent. Among the individual sector activities, agriculture showed a 92.2 per cent return over a three-year period. The repayment rate on loans was 84 per cent for livestock and 64 per cent for cottage industry activities. The results indicated that women had saved five to six hours of labour per day because of the provision of drinking water schemes in the project areas. An urban basic services project was developed to provide basic services to children and women in five selected poor urban areas.

21. The environment project initiated in 1990 was integrated within the small-scale farmer's programme and in the credit project. Under this project, 63,000 (out of 79,000 planned) fuel wood tree saplings were produced in 6 out of 17 planned nurseries; 15,000 (out of 30,000) fruit trees were planted; new household cooking stoves, low-cost latrines and compost pits were promoted; and related training activities were provided to field staff and community-level beneficiaries.

Advocacy and social mobilization

22. Programme communication has been a part of all programmes supported by UNICEF. Increased advocacy efforts have been targeted at various levels of the Government and at NGOs, the community and other development agencies. The activities have capitalized on the new opportunities created by the Convention on the Rights of the Child, the World Conference on Education for All, the South Asian Association for Regional Cooperation (SAARC) Year of the Girl Child and the World Summit for Children. Media mobilization activities were also undertaken in a consistent manner, with children's issues appearing regularly in the press. Among these was a national campaign on ORT, breast-feeding and EPI promotion. Facts for Life has proved an effective tool for social mobilization of various groups in support of child survival and development programmes.

23. The Ministry of Communications has established an Advisory Group for Child Welfare, and the mass media is increasingly highlighting issues related to child development. Publishing agencies have started producing reading materials for children. Communication-related experimentation, research and

advocacy are intended to create more positive images in the mass media of girls, women and children with disabilities.

Planning and evaluation

24. Together with the Government, other donors and NGOs, UNICEF supported and organized three seminars and two workshops on children's and women's rights, the Summit goals in the context of Nepal, the girl child and the SAARC initiative on the Decade of the Girl Child and the development of a national programme for children in the 1990s.

25. Support for microplanning and mapping in every district was a major factor in the success of EPI and will also help in future efforts to sustain it. A number of research studies and evaluations of EPI, vitamin A, CDD, essential drugs, basic education, water supply and sanitation and production credit for rural women were undertaken and supported. The results of the mid-term review were incorporated in programme adjustments and in programme development.

Lessons learned

26. Assessment of past experience indicates that, because of its very difficult terrain, Nepal needs to increase decentralization as a major strategy, with more decision-making autonomy given to the district level and below. It is clear that central-level planning has not been able to provide the majority of the population with basic services. It is necessary to explore alternatives starting from the community level.

27. Mapping and microplanning by districts was the key to achieving levels approaching universal child immunization coverage. The strategy provides skills training to district-level staff to develop plans, including target setting, cold-chain movements, immunization schedules and training and supervision schedules. Mapping and microplanning by districts seems to be the most effective means of achieving universal coverage goals.

28. Effective community involvement is the key to ensuring viability and continuity of projects and programmes, through the proven modalities of increasing social awareness and social mobilization.

29. There is better acceptance and use of health services by women in communities with female community volunteers and health workers. The same can be said of education; studies of the Cheli Beti programme indicate much better results with out-of-school girls when the teacher is female. Efforts to recruit larger numbers of female health and education workers must thus be strengthened.

30. There should be better targeting of rural, poor landless women for the provision of credit, the promotion of literacy and other basic services programmes.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

Recommended general resources: $25,000,000
Supplementary funding: $34,620,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health and nutrition	9 500	11 229	20 729
Education	7 000	5 352	12 352
Water supply and sanitation	2 000	11 602	13 602
Area-based programme	2 250	5 937	8 187
Advocacy and communication	1 500	500	2 000
Programme support	2 750	-	2 750
Total	25 000	34 620	59 620

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

31. The development of this country programme of cooperation has taken into consideration the goals and strategies for children and women in the Declaration and Plan of Action of the World Summit for Children. A national seminar on the goals and strategies for the 1990s and the mid-term review of the existing country programme provided the occasion for the formulation of an initial strategic framework of cooperation between the Government and UNICEF, in which general agreement was reached on goals and strategies. The situation analysis was further refined, and working groups, coordinated by the National Planning Commission, started work on a 10-year National Programme of Action for Children in pursuance of paragraph 34 of the Summit Declaration. This facilitated the preparation of the master plan of operations which incorporated UNICEF support for the national goals and strategies and modalities of the country programme for the period 1992-1996.

National goals for children and women

32. Nepal's goals for children and women in the 1990s, as incorporated in the ninth national development plan (1992-1998) are: (a) to reduce IMR and U5MR from 107 and 165 per 1,000 live births to 45 and 70 per 1,000 live births, respectively, and to reduce MMR by half from 850 to 425 per 100,000 live births; (b) to increase access to and use of safe drinking water from 37 to 80 per cent of the general population, and of sanitary means of excreta disposal for the urban population from 34 to 75 per cent and for the rural population from 6 to 31 per cent; (c) to increase access to primary education from 64 to 100 per cent of school-aged-children (gross enrolment) and to increase the enrolment of girls from 31 to 100 per cent; and (d) to reduce by one third moderate and severe malnutrition among children under five years old from 50 to 34 per cent. Among other types of malnutrition, the Government expects to reduce the incidence of low birth weight of newborn babies to levels below 10 per cent, to reduce iron deficiency anaemia from 78 to 52 per cent by the end of the decade, and to eliminate virtually vitamin A deficiency and IDD.

Country programme objectives

33. The UNICEF country programme will support progress towards the above-mentioned goals. The decrease in IMR can only be achieved by sustained reduction of morbidity through maintaining and sustaining universal levels of vaccination coverage and by eradicating poliomyelitis and neonatal tetanus. The health programme objectives are: (a) to reduce diarrhoea incidence by 1996 by 15 per cent of the 1990 levels to prevent 8,000 diarrhoea deaths per year during the entire programme of cooperation by increasing knowledge about diarrhoea treatment and the correct use of ORT from 3 per cent in 1990 to 25 per cent in 1996; (b) to reduce U5MR caused by ARI-related causes by one third by the year 2000, with an intermediate reduction of 17 per cent by 1996, so that 7,000 ARI deaths will be prevented per year; (c) to provide safe water supplies to 50 per cent of the population by 1996; (d) to expand primary school enrolment from 64 per cent of school-aged-children to 80 per cent by 1996, and increase the enrolment of girls from 31 to 65 per cent so that by the end of the decade they almost equal the number of boys enroled; (e) to increase the completion rate of primary education from 27 to 55 per cent by 1996; and (f) to lower the adult illiteracy rate from 65 per cent in 1990 to 51 per cent by 1996, with a strong focus on female literacy.

34. The programme will seek to reduce iron deficiency anaemia in women from 78 per cent in 1990 to 70 per cent by 1996. To achieve virtual elimination of vitamin A deficiency, the prevalence of Bitot Spots (spots on the eyes associated with vitamin A deficiency) must decrease from 2.1 per cent in 1990 to 1.5 per cent by 1996. The prevalence of IDD must be reduced from 40 to 28 per cent in the same period. All these measures are expected to reduce IMR from 107 to 80 and U5MR from 165 to 130 per 1,000 live births, respectively, by the end of the programme cycle in 1996.

Strategy

35. The National Planning Commission and the Ministry of Finance are the primary government agencies for cooperation with UNICEF. The operational planning will be done by task forces from the sectoral ministries. The country programme will promote planning from a community base ("empowering from the family up") with maximum involvement of NGOs and community organizations. The participation of female-headed households, communities, front-line workers and district- and regional-level officials in planning and management will be given momentum during this country programme period. Mapping and microplanning will be the main tool for programme planning and implementation. This country programme will continue to support and enlarge the activities of convergent services, but will move towards community-based programming by supporting related initiatives through NGOs and local councils. Priority will be given to human resources development, not only by improving the general health and nutritional status of children and women, but also by lowering illiteracy rates and improving the quality and coverage of education. High priorty will be given to poverty alleviation through income-generating activities linked to water supply and sanitation, women's involvement and literacy and also by ensuring that poor rural areas receive high priority in the delivery of basic services. UNICEF will strongly advocate putting children first in the allocation of national and donor resources. Social mobilization and communication and information activities will be strengthened to enhance awareness and to mobilize political will for the cause of children.

Health and nutrition

36. Activities will seek to empower families and community organizations with knowledge that will help them better to care for themselves. These efforts will benefit from materials based on Facts for Life. Front-line supporters at the community level include community health volunteers and TBAs, supported by the VHWs operating out of the health posts and providing regular monthly village contacts. UNICEF will support national efforts with a special focus on strengthening health services at the health-post level and below. The aim is to expand and sustain the 80 per cent levels of immunization coverage and to derive other maternal and child health (MCH) benefits from the extended outreach capacity and logistics system of the immunization programme. The CDD programme will emphasize mothers' preparation and use of ORS and continued appropriate feeding during diarrhoeal episodes. Support will also be continued for ORS production. Peripheral-level health workers will receive support to promote breast-feeding and appropriate weaning food practices and to provide safe water, sanitation and hygiene education so as to reduce morbidity from diarrhoeal diseases. Mothers and community health volunteers will be trained in the early recognition of pneumonia and health workers will be given appropriate training in the management and treatment of ARI. Operations research will be supported to provide data to assist in the formulation of communication strategies for projects on CDD and ARI control, as well as on safe motherhood. This project will also strengthen the capacity of health posts and district hospitals to manage cases of diarrhoea, pneumonia and complicated deliveries that are referred to them.

37. Advocacy for safe motherhood will emphasize the discouragement of early marriage and the preference for sons. Support will be provided for training 2,000 new TBAs and for refresher training for 6,000 more. Ways to strengthen the antenatal care referral mechanism with local and district health facilities will be developed. The skills of auxiliary nurses and VHWs to train and supervise TBAs will be upgraded. Family planning education and advocacy will be emphasized, and support for MCH training will be provided in close cooperation with the United Nations Population Fund (UNFPA), the World Bank and the United States Agency for International Development (USAID).

38. Support will be provided to family planning education through curriculum and textbook development at the formal primary-school and non-formal levels. Advocacy and communications projects will emphasize raising the age of marriage and will seek to spread knowledge about safe motherhood and family planning to the vast majority of Nepali families. Family planning education is also included in all aspects of the community-based programme. Close collaboration with UNFPA will be maintained for this purpose.

39. The current safe motherhood programme envisages a multifaceted preventive approach through awareness-building and health education. However, the detection and referral of difficult pregnancies has to be done by community health volunteers, VHWs and TBAs. They will be supported by both UNICEF and UNFPA and will provide safe motherhood and family planning advice along with other basic health areas. The national family planning project will support activities aimed at enhancing the capacity of district hospitals to act as referral centres for the management of complicated pregnancies, and for the promotion of family planning and MCH services at the district level.

40. The basic health support system will be a pivotal centre of development for the above-mentioned actions. It will be strengthened through support for the training of 4,000 VHWs and 1,200 auxiliary nurse midwives who work most closely with the communities; they will also be supported through the provision of essential drugs at the level of health post and below. Community involvement in the financing and management of services along the lines of the Bamako Initiative will be supported with a view to promoting sustainability in the PHC system. The health information systems for health posts and community health workers will be improved and simplified.

41. The nutrition programme of the Ministry of Health will be strengthened and expanded from the present three regions to national coverage. Support will be given to the training of VHWs and female community health volunteers, as well as to growth monitoring and the control of micronutrient deficiency disorders, maternal iron deficiency anaemia and vitamin A deficiency in children. The goitre and cretinism eradication programme will be supported by providing iodated oil injections for programmes and by enhancing coverage through use of iodized oil capsules. Greater access to capsules and iodated salt will be developed further.

Basic education

42. Curriculum revision at the primary school level will now be complemented by UNICEF support for the development and production of textbooks and materials, with a focus on the first three primary grades. The enhancement of reading, numeracy and life skills, including family planning, will be stressed. This will support the Government aim to make high-quality learning materials available free of charge at the primary level so as to increase enrolment and reduce the number of drop-outs.

43. Community support to education efforts will be promoted through a "village readiness" programme aimed at encouraging parents to send their children to school and to keep them there until they complete the primary cycle (preventing drop-outs), and more generally at increasing community participation in education efforts.

44. At the non-formal level, educational materials and funds for training will be provided to meet the increasing demand for adult literacy, particularly among women, and to support the alternative education programme for out-of-school children, particularly girls (the Cheli Beti programme). The community-based early child education and care project will seek to go to scale during the programme period.

Water supply and sanitation

45. The UNICEF-supported water supply and sanitation programme will have four projects tailored to geophysical areas using different and appropriate technologies: (a) gravity-flow schemes in the hilly areas; (b) spring protection in the hilly areas; (c) shallow wells in the terai (plains area); and (d) deepwells in the boulder formations between the hills and the terai. Expected to join the Government in implementing this programme are the Nepal Red Cross Society, Water Aid, six international volunteer agencies and some 60 local NGOs. Priority will be given to the coordination of UNICEF-assisted programmes with other donors.

46. The water supply programme will promote enhanced community participation, paying particular attention to the involvement of women in planning, maintenance and general health promotion activities. Greater intersectoral linkages with other programmes will also be emphasized, as will a range of appropriate training programmes. Some 2.5 million people will be reached, mainly in the Central and Eastern Development Regions of Nepal, which have the highest population density. Some additional beneficiaries will also be reached in other locations through the area-based programme: the small farmer's development project; production credit for rural women; and urban basic services.

Community-based programme

47. This programme will continue and enlarge the convergent services programme, and will also support activities to improve local-level urban planning and management through technical cooperation and training for municipal cities and city development authorities. The new modality will strengthen support to community-level initiatives for urban improvement through local NGOs and councils. It comprises five complementary projects (the small-scale farmers' development project, the production credit for rural women project, urban basic services, literacy and the environment) and will enhance significantly the achievement of national goals for children and development for the 1990s. The target is to reach over 1.5 million families living below the poverty level by 1996. This programme will serve 1,200 village development committees country-wide and will continue its focus on poverty alleviation through credit, self-help and the provision of integrated basic services, with participation from NGOs and local community institutions.

Advocacy and communications

48. The advocacy and communications programme will provide essential support towards reaching the goals for children in the 1990s. Advocacy will focus on children's rights, the girl child, women in development and development education. Project support communications will be an integral part of efforts for immunization, CDD, safe motherhood, family planning, nutrition education, sanitation and hygiene and the village readiness programme in basic education. Facts for Life constitutes a communications resource that cuts across all programmes. The advocacy and communications programme will also seek to build alliances for children by mobilizing volunteer groups, NGOs, public organizations, professional bodies and donor agencies.

Planning, monitoring and evaluation

49. The National Council for Child Development, with the National Planning Commission as its secretariat, will provide the overall umbrella for child monitoring. Monitoring capacities of relevant sectoral ministries and their subnational organs will need to be addressed. UNICEF proposes to support the development of national monitoring mechanisms in support of the full implementation of the Convention on the Rights of the Child and the goals for children in the 1990s.

50. Operational research activities will include training for mapping and microplanning methods successfully used for EPI. This methodology will be expanded to support community-based development in all projects. This effort will be complemented by the development of research mechanisms and the establishment of a monitoring and evaluation system.

51. In addition to annual reviews of programmes and a mid-term review scheduled for 1994, other planned evaluation activities include an EPI evaluation in 1994; knowledge, attitude and practices studies on community self-financing for essential drugs in 1992-1993; an impact evaluation of the

small farmer development programme in 1994; an impact evaluation of the environment project in 1994; and baseline surveys for 15 municipalities under the urban basic services project in 1992-1993. In addition, sectoral programme evaluations, especially of the health sector, have been planned. Some of them will use sentinel sites and/or rapid assessment methodology. A monitoring and evaluation plan for the country programme is incorporated in the master plan of operations.

Cooperation with other agencies

52. This programme has been developed in close cooperation with other United Nations agencies such as UNDP, UNFPA, the Food and Agriculture Organization of the United Nations (FAO), the World Food Programme (WFP) and WHO. There have also been consultations with the World Bank and the Asian Development Bank. Other bilateral agencies and more than 20 NGOs working for children and women in Nepal will be involved in programme implementation.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Nepal (1990 and earlier years) UNICEF country classification

Under-five mortality rate	189	(1990)	Very high U5MR
Infant mortality rate	123	(1990)	Very high IMR
GNP per capita	$ 170	(1990)	Low GNP
Total population	19.1 Million	(1990)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	537	639	694	725
Infant deaths (under 1)	(thousands)	85	91	93	89
Under-five deaths	(thousands)	133	142	144	137
Under-five mortality rate (per 1,000 live births)		247	222	207	189
Infant mortality rate (under 1) (per 1,000 live births)		159	143	134	123

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1975)	Moderate & severe	70a	..
	Severe	5a	..
Babies with low birth weight (%)		..	..
% of primary school children reaching final grade (1980/1988)		..	27*

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1976)		92/ 92/ 82	../ ../ ..
Prevalence of wasting (%)		..	..
Prevalence of stunting (%)		..	..
Daily per capita calorie supply (% of requirements, 1979-1981/1988)		91	94
Food production per capita index (Index 1979-1981=100, 1980/1990)		102	109
Household expenditure (% of total income, 1980-1985)	All food/cereals		57/ 38

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1989)			14
Access to health services (% of population, 1980/1987)	Total	..	..
	Urban/rural	../..	../..
Access to safe water (% of population, 1980/1990)	Total	12	37
	Urban/rural	82/ 7	66/ 34
Access to adequate sanitation (% of population, 1980/1985)	Total	2	2
	Urban/rural	16/ 1	17/ 1
Births attended by trained personnel (%, 1980/1987)		..	6
Maternal mortality rate (per 100,000 live births, 1979/1986)		..	830

Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	32	67	99
	DPT	16	32	85
	Polio	1	20	84
	Measles	2	46	71
Pregnant women (%) immunized against	Tetanus	4	10	28

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TABLE 1 (continued)

Nepal

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	82/ ..	86/ 64
(%, 1980/1988)	Male	115/ ..	112/ 84
	Female	48/ ..	57/ 43
Secondary enrolment ratio (gross/net)	Total	21/ ..	30/ 23
(%, 1980/1988)	Male	33/ ..	42/ 32
	Female	9/ ..	17/ 13
Adult literacy rate, 15 years & older	Total	13	26
(%, 1970/1990)	Male/female	23/ 3	38/ 13
Radio/television sets			
(per 1,000 population, 1980/1988)		20/ 0	33/ 2

DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Million)	11.5	14.9	16.9	19.1	24.1
Population aged 0-15 years	(Million)	..	6.4	7.5	8.5	10.1
Population aged 0-4 years	(Thousands)	..	2421.5	2882.5	3080.9	3466.1
Urban population (% of total)		4	6	8	10	14
Life expectancy at birth	Total	42	47	50	52	57
(years)	Male	43	48	50	53	58
	Female	42	46	49	52	57
Total fertility rate		6.3	6.4	6.1	5.7	4.7
Crude birth rate (per 1,000 population)		46	44	41	38	32
Crude death rate (per 1,000 population)		22	18	16	14	11

		About 1980	Most recent
Contraceptive prevalence rate		2	14
(%, 1976/1986)			
Population annual growth rate	Total	2.4	2.5
(%, 1965-1980/1980-1990)	Urban	5.1	7.0

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		0.0	1.8
(%, 1965-1980/1980-1990)			
Inflation rate (%, 1965-1980/1980-1989)		8	9
Population in absolute poverty	Urban/rural	55/ 61	../ ..
(%, 1977)			
Household income share	Top 20%/bottom 40%	59/ 13	../ ..
(%, 1976-1977)			
Government expenditure	Health/education	4/ 10	6/ 9
(% of total expenditure, 1980/1989)	Defence	7	7
Household expenditure	Health/education		../..
(% of total income, 1980-1985)			
Official development assistance:	US$ millions	163	488
(1980/1989)	As % of GNP	8	15
Debt service			
(% of goods & services exports, 1980/1989)		2	14

a/ Rural only.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1988-1991 a/

(In thousands of United States dollars)

COUNTRY: NEPAL
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $17,500,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	5406	1454	494	110	749		1146	79	7795	1643	9438
Water supply and sanitation	55	5166	78	139	532	947	224	769	889	7021	7910
Nutrition	1168	506	73	150	31	18	591	653	1863	1327	3190
Education	437	97	475	114	444	61	306	839	1662	1111	2773
Community organization and development	425	1	155	80	55				635	81	716
Women-centred programme	183	280	171	266	164	38	710	965	1228	1549	2777
Advocacy	100		25		203		117		445		445
Planning and project support	182		34		626		385	35	1227	35	1262
Freight	595	192							595	192	787
GRAND TOTAL	8551	7696	1505	859	2804	1064	3479	3340	16339	12959	29298

GR = General resources.
FSF = Funded supplementary funding.
a/ Due to an increase of annual programme budget levels, funds were disbursed ahead of schedule.

/...

TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: NEPAL Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Health and nutrition	GR	1900	1900	1900	1900	1900	9500
	FSF	771					771
	NSF	1629	2400	2400	2400	2400	11229
Education	GR	1400	1400	1400	1400	1400	7000
	FSF	1004	144				1148
	NSF	296	1156	1300	1300	1300	5352
Water supply and sanitation with women's involvement	GR	400	400	400	400	400	2000
	FSF	1995	403				2398
	NSF	805	2397	2800	2800	2800	11602
Social mobilization and advocacy	GR	300	300	300	300	300	1500
	NSF	100	100	100	100	100	500
Programme support	GR	550	550	550	550	550	2750
Integrated area-based programme	GR	450	450	450	450	450	2250
	FSF	865	150	48			1063
	NSF	536	1250	1351	1400	1400	5937
TOTAL	GR a/	5000	5000	5000	5000	5000	25000
	FSF	4635	697	48			5380
	NSF	3366	7303	7951	8000	8000	34620
GRAND TOTAL		13001	13000	12999	13000	13000	65000

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.
a/ In addition, there are $150,000 allocations approved previously for integrated programme and $200,000 was allocated prior to 1992 for unfunded supplementary funds.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: NEPAL	Number of posts	Amount (Thousands of United States dollars)
FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	4	1016
Local national Professional and General Service established posts	16	207
Operating costs		760
Total	20	1983
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	11	2175
Supplementary funds	4	425
Local national Professional and General Service project posts		
General resources	45	347
Supplementary funds	13	105
Total	73	3052

a/ For information source, see the 1992 revised post authorization table, dated 23 July 1991.

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UNITED NATIONS CHILDREN'S FUND
Programme Committee
1992 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Pakistan

The Executive Director recommends that the Executive Board approve the country programme of Pakistan for the period 1992-1996 in the amount of $71.5 million from general resources, subject to the availability of funds, and $53.5 million in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. Although Pakistan's economy is growing steadily, the country now has a heavy burden of debt servicing. Unemployment is high, and the workforce, much of which is employed in the informal sector, suffers from low levels of training and productivity. Social indicators reflect a general apathy in the past towards social sector development, which has not received its due share of funding. According to one estimate, 30 per cent of the population lives below the poverty line. The populations in larger cities are better off than those in rural areas and smaller towns, but unplanned urban growth has led to pockets of severe urban poverty.

2. Pakistan's population is now approximately 122.6 million and its growth rate of 3.6 per cent per year is one of the highest in the world, posing multiple threats to continued economic and social development. Family planning services have not yet had an impact. Data from 1984-1985 indicate that only 11 per cent of married women has ever used any contraceptive method. Population growth is related to the traditional family system and expectations for women to bear large numbers of male children. Such multiple, unspaced pregnancies, combined with poor maternal nutrition and underdeveloped maternity services, result in a high maternal mortality rate of at least 500 per 100,000 live births.

3. The same factors affect the health of infants and young children. Some 25 per cent of babies are of low birth weight. Infant and under-five mortality are approximately 104 and 158 per 1,000 live births, respectively. The major causes are neonatal tetanus, diarrhoea, acute respiratory infections (ARI) and measles. However, programmes to combat those threats are being implemented, and the expanded programme on immunization (EPI) has now immunized over 80 per cent of children under one year of age with all EPI antigens except measles, for which some 79 per cent of children under one year old have been reached. Although breast-feeding has remained the norm, breast milk is often improperly supplemented, and weaning often takes place too early and without the adequate supplementation of nutritious foods. As a result of those factors, and of sheer poverty, only 43 per cent of children nationwide are well-nourished. In addition to protein-energy malnutrition, there are serious problems of iron, iodine and vitamin A deficiencies. Pakistan also has a high rate of various childhood disabilities, without the highly developed services to treat, care for and rehabilitate those affected.

4. Pakistan has increasing environmental problems, including pollution, deforestation and waterlogging. The provision of clean water and proper sanitation is still inadequate, with only 45 per cent of the rural population having access to clean water and only 10 per cent to proper sanitation. Coverage is better in towns, but the lack of sanitation, drainage and proper solid waste disposal are among the many problems faced by dwellers in low-income urban settlements. However, experiments in the community-based provision of water and sanitation have been successful and are now receiving increased official support.

5. The traditional extended family is still strong. Where other family patterns are emerging, there is as yet insufficient attention to the material and psychological needs of young children. Organized preschool education is very rare.

6. The existing number of primary schools caters to only 63 per cent of children five to nine years of age. These schools often have poor physical facilities and too few teachers. There are also problems with the curriculum and management of primary education. The importance of education is still not sufficiently accepted by parents, particularly with regard to girls. The national adult literacy rate is only 31 per cent, and is far lower in rural areas.

7. There are an estimated 8 million working children, many of whom are driven by their families' poverty to work long hours in hazardous, unhealthy trades for pitiful wages. Work generally keeps them away from school, with a resulting loss to society as a whole. There are also children in other especially difficult circumstances, such as the small numbers exposed to bonded labour.

8. The problems faced by children in general are even more severe for girls. Some evidence, including Pakistan's exceptionally high overall ratio of males to females, suggests that unconscious neglect leads to greater mortality among girls. Prevailing norms restrict girls' access to health care, education and recreation, and may even seclude them inside the house. The primary school enrolment rate for girls is only 45 per cent, compared with 79 per cent for boys. The declaration of 1990 as the South Asian Association for Regional Cooperation (SAARC) Year of the Girl Child and the 1990s as the SAARC Decade of the Girl Child has begun to focus attention on those concerns.

9. Pakistan's cultural milieu supports a patriarchal family system in which women are socialized to be submissive and obedient. Women remain under the guardianship of men throughout their lives depending on their age and marital status, which probably has profound implications for women's development. Early marriage is still very common for girls, perpetuating the cycle of multiple pregnancies and poor health of mothers and children. Women work hard in the home and outside; their participation in the economy, especially in agriculture, is only beginning to be fully recognized and recorded. A significant and growing minority of women are now working in higher status jobs in the formal economy, but they still face obstacles, including a lack of training and educational facilities, a lack of child-care facilities and discrimination in the workplace and outside.

10. The situation of children and women is generally unfavourable, and worse than might be expected for a country in Pakistan's economic position. Nevertheless, the constitution and recent legislation and policy have all created an environment suitable for development in the sectors that will most benefit children and women. The main obstacle to such developments is the historic underfunding of the social sector, although there are arguably also problems in the government structures that plan and implement development

activities. Pakistan is a signatory to the World Summit Declaration and Plan of Action. The goals contained in that Plan of Action coincide closely with the goals contained in Pakistan's own national plans.

PROGRAMME COOPERATION, 1988-1991

11. The country programme for 1988-1992 has been reduced to four years because the annual programme budget levels were increased and the approved funds disbursed ahead of schedule.

12. A January 1991 Government/World Health Organization (WHO)/UNICEF evaluation of EPI indicated that Pakistan has reached over 80 per cent coverage for all childhood EPI antigens except measles. Special emphasis was placed on urban populations in which coverage had been shown to be lower than rural areas. A Federal Communications Advisory Group was established at the National Institute of Health as part of a major emphasis on programme communications. A sentinel surveillance system has been initiated for the EPI target diseases. Coverage of women of child-bearing age with tetanus toxoid increased from 27 per cent in 1987 to 32 per cent in 1989 and was estimated at 71 per cent by an international evaluation in early 1991. Female vaccinators and traditional birth attendants (TBAs) served to increase coverage of unprotected women.

13. The control of diarrhoeal diseases (CDD) programme emphasized training of health workers in correct case management of acute diarrhoea through the establishment of 10 diarrhoea training units. Standard treatment by private practitioners, paramedical workers and chemists has also been promoted. The work of the Federal Communications Advisory Group has created awareness among mothers regarding the availability of oral rehydration salt (ORS), although household surveys have shown that only approximately 20 per cent of mothers use ORS correctly. Efforts in this area have been coordinated with EPI, breast-feeding promotion, improved infant feeding practices, health education, water supply and sanitation activities and hygiene education.

14. The development of the national ARI control programme has been supported since 1989. Workshops with senior health administrators, academic paediatricians, decision makers and private paediatricians were held to identify programme objectives, develop national guidelines, plan programme implementation and prepare for the development of ARI training units at nine sites throughout the country.

15. In order to promote improved maternal and neonatal health, more than 40,000 new TBAs have been trained, and provincial monitoring and refresher training systems have been established. Operational research studies to strengthen the linkages between TBAs and local health facilities have been conducted. Child-spacing activities have been promoted by TBAs using motivation techniques. Pilot efforts to promote primary health care (PHC) were supported in the Islamabad Capital Territory and Sindh province. A pilot project for TBAs in Sindh provided a model for expanding the role of the TBA

to that of a PHC worker through further training in EPI, CDD, hygiene, malaria and child-spacing. In the area of health education, support has been provided to develop and produce training and communication materials and to strengthen provincial-level capacity.

Nutrition

16. Selected growth monitoring activities have been supported and nutrition education activities expanded through EPI staff and TBAs. There have been training activities for 400 medical officers, 200 lady health visitors (LHVs) and 18 TBAs. In collaboration with the Government/World Food Programme (WFP) supplementary nutrition programme, 700 medical officers and 2,200 LHVs have been trained at 1,600 outlets. Research studies to assess the nutritional status of hard-to-reach populations, develop an inventory of nutrition training programmes and review available information on vitamin A deficiency have been supported.

17. Breast-feeding steering committees have been formed to coordinate efforts to promote exclusive breast-feeding and healthy infant feeding practices. Selective operational research studies to assess trends in breast-feeding practices have been supported. Lactation management clinics have been established in a number of teaching hospitals, and the Ministry of Health has introduced a breast-feeding policy for hospitals and health centres along the lines of the "baby-friendly hospital" approach. Advocacy for the adoption of the International Code of Marketing of Breast Milk Substitutes continues at the policy level.

18. Both short- and long-term strategies are being supported for the national iodine deficiency disorders (IDD) control programme. Iodized oil capsules and injections have been provided for use in the highly endemic areas of northern Pakistan, as have training costs, logistical support and health education assistance. EPI staff in the North-West Frontier Provinces have been trained in IDD and are distributing capsules. Assistance has also been provided to expand the availability and use of iodized salt as the long-term strategy.

Water supply, environmental sanitation and hygiene education

19. An integrated package of water supply, household sanitation and personal hygiene at the community level in underserved areas has been the major thrust of the programme. Appropriate and low-cost technologies have been promoted, including the introduction of the "Afridev" model village-level operation and maintenance hand-pump in the lowlands and gravity-fed pipe systems in the mountainous areas. Starting from a demonstration phase in five districts, the programme has now expanded to 67 districts, with some 3,500 hand-pumps installed against the planned 6,000 and some 280 gravity-fed systems completed or under way against the planned 850 systems. The sanitation component promoted the household pour-flush or ventilated improved pit latrine model, but only about 8,000 of the planned 40,500 latrines were constructed. Efforts have started since 1991 to strengthen the training and hygiene education component of the programme, including the promotion of community participation

in the installation, operation and maintenance of water supply and sanitation facilities. Advocacy efforts have promoted the community-based, village-level operation and maintenance concept as a means to universalize water supply access, and the Government is now allocating more of its own resources to this strategy. To ensure sustainability, private sector manufacturers of the Afridev hand-pump have also been encouraged, with some 4,000 pumps per year now being entirely locally produced.

Education

20. A special focus was maintained on female education in all basic education activities. Support was extended to projects targeting females in rural and low-income urban areas, including the in-service and pre-service training of female teachers, outreach teacher training in Balochistan and the training of learning coordinators in the North-West Frontier Provinces. Supplies and equipment were provided to remote female primary schools in Jammu and Kashmir. Non-formal primary education was supported through home schools, street schools and grass-roots non-governmental organizations (NGOs) in Sindh and the North-West Frontier Provinces. Integrated functional education was supported through Allama Iqbal Open University, Islamabad, and female literacy through NGOs in northern areas. After a delayed start, the primary education curriculum reform project picked up momentum in 1989-1991.

21. A number of advocacy efforts were supported before and as a follow-up to the World Conference on Education for All in 1990. Case-studies and situation analyses were made and seminars and workshops organized to disseminate information on the significance of basic education in overall national development. A task force in the Ministry of Education was supported to follow up Conference activities.

Women in development

22. Initiatives in this area aimed at mainstreaming gender concerns into sectoral planning and developing field approaches to increase options for education, health and economic participation. Such activities included documentation, advocacy, training, information dissemination and networking. Some success has been achieved in awareness creation, especially on the issue of the girl child and adolescent, information generation and sharing, and in-country and SAARC regional networking. Field programme action included strengthening integrated activities at existing women's centres, organizing female youth groups, vocational and micro-enterprise skill training, and facilitating access to credit. Outreach improved from about 100 locations in 1988 to some 500 project sites by 1991 against the targeted 1,000 locations. Constraints included the limited outreach capacity of NGOs; the inability of mid-level government and NGO field staff to work as catalysts, especially for group formation; a shortage of training facilities geared to specific needs of staff working with young girls; and inadequate counterpart funds for infrastructural costs.

Urban basic services

23. Based on experience gained from 1982 to 1987 in Lahore and Karachi, support was expanded to 34 low-income areas in six cities. Activities included EPI, literacy and non-formal education initiatives, sanitation and support to local government structures, including the recruitment of community organizers. The Orangi Pilot Project and the Municipal Training and Research Institute of the Ministry of Local Government were strengthened and have trained more than 150 community organizers, NGOs and government personnel since 1990. Linkages to major donor-aided projects in Sindh and Peshawar were initiated.

Childhood disability

24. The programme focused on enhancing awareness and promoting community-level services and capacity-building of government and NGOs. Innovative community-based projects were supported in three provinces, reaching some 600 disabled children and their families with home care support services. Low-cost rehabilitative technology was promoted in two provinces serving over 1,000 children. A pilot project that aimed at the identification and referral of primary schoolchildren with impairments was successfully launched in Karachi. Workshops and training courses on home and community services for over 200 workers were supported. A handbook on disabilities and other materials were produced for outreach workers.

Children in especially difficult circumstances

25. As a new area of collaboration, activities focused on research on children in especially difficult circumstances (CEDC) with studies covering child labour, children in prisons and orphanages and children under circumstances of pledged labour in the carpet and brick-making industries. Workshops at the provincial level and extensive media coverage have contributed to increased awareness. Some 15 NGOs are now involved in CEDC-related activities. Project activities included non-formal education for children working in the brick kiln in Punjab, community development in the North-West Frontier Provinces and three demonstration projects for working children in Karachi.

Planning, monitoring and evaluation

26. Improvement in programme planning, monitoring and evaluation was achieved through the identification of data gaps, streamlining project monitoring systems, specific research studies and third-party project evaluations. UNICEF has collaborated with the National Census Organization to generate more gender-sensitive data from the 1991 census. The Statistics Division was supported to improve its knowledge of social indicators and to strengthen a district-based surveillance system to monitor the 1990s goals for children. In Sindh, a community-based surveillance system has been supported. UNICEF is assisting the Government to develop a national programme of action as a follow-up to the World Summit for Children. Support has also been extended

for a study of adjustment with a human face as an input to the preparation of the Eighth Five-Year Plan.

Information, advocacy and social mobilization

27. Information and programme communication have been part of all UNICEF-supported programmes. Increased advocacy efforts have been targeted at various levels in Government and at NGOs, the community and other development agencies, and have particularly capitalized on the new opportunities created by the Convention on the Rights of the Child, the World Conference on Education for All, the SAARC Year of the Girl Child and the World Summit for Children. Children's issues appearing regularly in the press. Facts for Life has proved an effective tool for social mobilization of various groups in support of child survival and development programmes.

Lessons learned

28. A mid-term review in May 1990 provided the basis for adjustments in the country programme in 1990 and 1991 and for initiating the planning process for the 1992-1996 programme of cooperation. Among the lessons learned were: the importance of placing a particular focus on the unmet needs of the girl child as a beneficiary of social services; the need to strengthen the delivery of services through all sectors to low-income, unreached urban areas; the need to continue the focus on training of mid-level staff, with particular emphasis on supervisory functions; the importance of reinforcing efforts to promote community participation in all programmes; and the importance of continuing and taking further advocacy efforts to mobilize government and other partners towards a first call for children. In general, the mid-term review and other more specific evaluations endorsed the priorities and scope of UNICEF cooperation in Pakistan and recommended its continuation with some refocusing in the next cycle towards the goals for children in the 1990s.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

Recommended general resources: $71,500,000
Supplementary funding: $53,500,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Planning and monitoring	1 100	-	1 100
Advocacy and social mobilization	2 500	-	2 500
Child health	21 450	9 000	30 450
Safe motherhood	5 000	4 500	9 500
Nutrition	5 550	-	5 550
Education	10 400	10 000	20 400
Women in development	4 300	3 000	7 300
Water supply and sanitation	11 700	22 500	34 200
Children in especially difficult circumstances	1 500	2 000	3 500
Reaching the urban unreached	1 500	2 500	4 000
Programme support	6 500	-	6 500
Total	71 500	53 500	125 000

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects as shown in table 3.

29. The 1992-1996 programme of cooperation aims to advance the following national goals and objectives: (a) to place children's concerns high on the political and development agenda in the implementation of the World Summit Declaration and the Convention on the Rights of the Child; (b) to improve child survival by reducing infant and under-five mortality rates to 70 and 100 per 1,000 live births, respectively, by 1996; (c) to promote safe motherhood and to reduce maternal mortality to 300 per 100,000 live births by 1996; (d) to contribute to a reduction in population growth; (e) to expand coverage of water supply facilities from 55 to 65 per cent and sanitation facilities from 23 to 33 per cent and to eradicate dracunculiasis (guinea worm disease) by 1996; (f) to promote the social and intellectual development of children, particularly the girl child, through basic education; (g) to promote the integration of the disabled and socially disadvantaged, particularly working children in social services, especially basic education; and (h) to improve the situation of women and to enhance their status and role in the family, the

community and in national development. Particular emphasis will be placed on reaching remote rural areas and low-income urban areas.

Planning and monitoring

30. In support of the government commitment to the World Summit Plan of Action, the programme will assist the formulation and periodic updating of both the national and provincial programmes of action for children. The programme will also promote social action for children and women by facilitating a more systematic involvement of NGOs in the planning, implementation and monitoring of programmes for children. Training and technical assistance will also be supported. In order to track progress towards the goals for children in the 1990s, the programme will support the monitoring of basic indicators on children and women. The programme will seek to strengthen national and provincial capacities for collecting, analysing and publishing data on children, disaggregated by gender and by region, to ensure an equitable impact on girls and women and on other disparities. It will also seek to strengthen capacities for developing environment-friendly development policies, especially as they impact on children and women. Research of a qualitative nature on the situation of children and women will also be supported. Institutional networking with the United Nations Development Programme (UNDP) and the World Bank on human development will be pursued.

Advocacy and social mobilization

31. Advocacy and social mobilization will involve approximately 8 per cent of the resources planned for the five-year period. Advocacy for specific programme approaches and operational and technical options to improve the service delivery capacity for children and women are reflected in all sectoral programmes. The programme will also support a broad-based process of informing and involving strategically placed allies. The programme will seek to sensitize policy makers, legislators and community leaders about children's issues and to support the development and dissemination of information and communication materials in support of the programme objectives. Facts for Life will be used as a basic reference for advocacy messages on children and women.

Child health

32. The programme is based on targeted interventions to reduce childhood and maternal mortality while strengthening the health sector infrastructure necessary to develop a comprehensive PHC system. Specific focus will be placed on monitoring progress towards reaching the goals for children in the 1990s.

33. Emphasis will be placed on sustaining the achievements of universal child immunization, specifically on increasing tetanus toxoid coverage of women of child-bearing age, poliomyelitis eradication and reductions in measles morbidity and mortality. Strategies will be developed to identify and immunize socially and geographically disadvantaged populations in rural and

urban settings. Efforts will be made to reduce the dependency on outreach activities to deliver routine immunizations. Improved management systems for maintenance of the cold chain and transportation will be developed. Successful communications efforts will be expanded to promote complete immunization. Essential PHC interventions such as oral rehydration, the provision of iodized oil capsules and basic health education services will be delivered by EPI staff. Close collaboration with WHO, the United States Agency for International Development (USAID), the Canadian International Development Agency (CIDA), Rotary International and the World Bank will be continued.

34. The CDD programme will strengthen current activities to reduce mortality and morbidity from diarrhoeal diseases in children under five years of age. Although an estimated 80 per cent of mothers know about oral rehydration, additional emphasis is necessary to ensure that they know how to prepare and use ORS as well as to continue feeding during diarrhoeal episodes. ORS packets will be procured for training activities and demand-creation activities will be supported to increase ORS production by the private sector. CDD training for paramedical staff will be expanded and orientation workshops for private practitioners will be continued to improve their case management practices. Health education, breast-feeding promotion, nutrition education, safe water, sanitation and hygiene education activities will contribute to reductions in morbidity from diarrhoeal diseases.

35. Recent activities to establish a national programme for the control of ARI in children under five years of age will continue. Emphasis will be placed on expanding training of medical officers in case management, orienting private practitioners in new concepts of treatment, training health workers at clinic and first referral levels in case management, and drugs management. Operational research studies to clarify the clinical significance and extent of antibiotic resistance will be conducted and ethnographic studies will be supported to provide the data necessary to formulate a communications strategy.

36. Additional activities will include specific measures to improve the health education capacity of the provincial departments of health, support to model community health worker programmes, collaborative efforts to redesign and implement a simplified health information system for first-level care facilities, strengthened senior-level and mid-level management training and consideration of the development of a national field epidemiology training programme. Operational research activities will include support for the creation of a national research coordination mechanism, increased training in research methodology and funding of studies addressing selected essential national health research priorities.

Safe motherhood

37. Advocacy for safe motherhood, including discouraging early marriage and the preference for sons, will be emphasized. Existing provincial programmes to train TBAs will be expanded during the first two years through funding from CIDA. A revised curriculum will be utilized for the training of 30,000 new

TBAs. Mechanisms to provide refresher training for 24,000 TBAs annually, to create provincial and national databases of trained TBAs and to strengthen referral mechanisms for TBAs with local health facilities will be developed. The skills of LHVs to train and supervise TBAs will be upgraded. Studies will be supported to address priorities such as the referral of high-risk pregnancies and utilizing TBAs for the promotion of child-spacing.

38. Support will be provided to improve the quality of maternal and child health (MCH) care workers. Emphasis will be placed on upgrading the technical quality and clinical skills of antenatal care. Through collaboration with the World Bank Family Health Project, additional training, equipment and supervision will be provided to the current network of MCH centres.

39. New initiatives in support of the national population programme will be formulated. Collaboration will be maintained with other donors already involved in family planning such as the United Nations Population Fund (UNFPA), USAID, the World Bank, the United Kingdom Overseas Development Administration and CIDA. Advocacy and social mobilization for family planning and child-spacing activities will be key aspects of initial assistance. Support for the training of health department and NGO staff in counselling for family planning services will also be provided.

Nutrition

40. The programme will focus on extending the sites for nutrition education, expansion of targeted growth monitoring, improved coordination of nutrition surveillance and directed communications efforts. A nutrition curriculum for medical officers, LHVs and paramedical staff will be developed, pre-tested and integrated into other relevant child survival training activities. Community-based nutrition projects will be developed as models for initiating PHC programmes.

41. Support will continue to national and provincial breast-feeding steering committee activities, as will support for recently developed national breast-feeding policies for "baby-friendly" hospitals and health facilities. A national training course in lactation management will be developed to expand the national network of locations promoting breast-feeding to new mothers. Advocacy efforts will continue to encourage the Government to adopt the International Code of Marketing of Breast Milk Substitutes. TBAs will be utilized to improve breast-feeding and infant feeding practices. Applied research will be supported to identify the most effective approaches to increasing exclusive breast-feeding for at least four months and to identify healthy infant feeding practices that need reinforcement.

42. Support will continue for the national IDD control programme. Short-term activities to provide iodized oil through capsules or injections in the endemic target area of northern Pakistan will be supported by increased training, supply of commodities and transport, and further integration of IDD activities into EPI and schools. Expanded production of iodinated salt will be stimulated and increased communications activities will be promoted to

stimulate demand. Efforts to improve the surveillance and monitoring of programme activities will be essential for achieving national objectives. Intensified advocacy for legislation to mandate the iodination of salt will be promoted.

43. Iron and folate supplementation for pregnant and lactating females will be promoted. Targeted surveys to identify high-risk populations with vitamin A deficiency will be supported to plan nutrition education and supplementation activities. National guidelines regarding the indications for prophylactic use of vitamin A for selected indications will be promoted.

Basic education

44. Cooperation in this field will focus on improving educational opportunities for the girl child in particular, as well as for younger women. Support will focus on selected districts in three areas: improvement of primary education through formal and non-formal channels, with particular attention to the needs of girls and disadvantaged children, including working children and the disabled; promotion of female literacy with emphasis on functional approaches to reinforce other elements of child survival, protection and development; and advocacy in support of basic education, demand-creation and coordination with other agencies.

45. In formal primary education, the programme will focus on promoting female enrolment and reducing drop-outs. Working together with other partners, emphasis will be placed on improving the efficiency, effectiveness and relevance of the educational system. The primary education curriculum reform project will be continued, but with adjustments, taking into account the work of the World Bank and USAID in the same field. Strengthening of district-level management and female teacher training will be supported. Demonstration activities on the integration of disabled children in regular schools will continue to be supported, as will activities to detect impairments in schoolchildren. Non-formal approaches to primary education will be supported both at the policy level with Government and at the service delivery level through support to NGOs. The programme will support the improvement of the quality of learning in non-formal schools.

46. In view of the past lack of continuity in national literacy efforts, the programme will initially concentrate on supporting policy formulation, building the institutional basis for female literacy, including training of literacy teachers, and the development of literacy materials. Field-level activities will also be supported, particularly through NGOs. The programme will support awareness creation on basic education and literacy and promote research for the development of information and communication activities.

Women in development

47. The programme will focus on improved health and educational opportunities for girls and women, as well as activities to improve the economic status of disadvantaged rural and urban women and adolescents. It will provide for

field-level support through the Government and NGOs to non-formal education, to group formation for women and adolescents and to skills training and credit schemes to encourage employment and income-generation for low-income women. Field-level activities will aim to reach a minimum of 100,000 girls and women directly through 1,000 women's centres, 500 female youth groups and 100 credit groups. In line with the SAARC Decade of the Girl Child, the programme will promote research, training, advocacy and planning actions through government agencies, the media and NGOs to reduce the preference for male children and to ensure a more considered focus on the girl child in social sectoral planning and service delivery.

Water supply, environmental sanitation and hygiene education

48. The water supply, environmental sanitation and hygiene education programme will focus on advocacy through field-level action for the adoption of low-cost, appropriate technology, water supply and sanitation systems, combined with community involvement and training in systems installation, operation and maintenance and in hygiene education. The programme will support the installation of 20,000 hand-pumps for disadvantaged communities in rainfed lowland areas and 1,000 gravity-fed piped systems in mountainous areas. The few remaining pockets of dracunculiasis will be prioritized. The programme will also support the promotion of appropriate technologies and operational approaches for replicable household sanitation and hygiene education in rural communities and, as a new emphasis, in low-income urban areas. Support will be given to safe water supply, proper excreta disposal and improved hygiene standards in 11,000 primary schools, particularly for girls, to improve physical health conditions in these schools, to enhance enrolment and to complement the hygiene education elements of the classroom curriculum. The programme will also address improved sanitation and hygiene education in canal-irrigated areas. UNICEF and the Government will collaborate closely with other agencies in policy formation, advocacy, public information and monitoring and research for water supply, sanitation and hygiene education.

Children in especially difficult circumstances

49. The programme will address the needs of children whose circumstances preclude or inhibit their access to normal services and opportunities. This group includes children with disabilities, children below the age of 15 years who are working under exploitative or dangerous conditions, children in institutions and children subject to other forms of abuse or neglect. The programme will focus on advocacy to implement the relevant provisions of the Convention on the Rights of the Child and to create public awareness of the problems and needs of particularly disadvantaged children. For disabled children, support will be given to promoting ways of serving their needs through the mainstream of the health and education systems, and to strengthening parental and community awareness and actions. For working children, activities will be supported to improve their participation in basic education primarily through non-formal means. Efforts will be made to protect the child at the work place and to promote the abolition of child labour in

selected hazardous industries. For other categories of children in special circumstances, the programme will support advocacy, research and analysis and demonstration activities in selected institutions to minimize the worst effects of growing up outside a normal family environment. In addition to the leading role of the Government, the programme will seek to involve a wide range of NGOs and the private sector.

Reaching the urban unreached

50. Given the rapidly growing urban population and the increasing numbers of low-income settlements within cities that do not yet have adequate basic social services for children and women, the programme will promote the inclusion of unreached urban areas in the coverage of sectoral programmes, especially in relation to MCH care, basic education, opportunities for women and environmental sanitation. Building on the baseline data gathered during 1988-1991, the programme will focus on advocacy with other national and international agencies involved in urban development to ensure that the needs of unreached urban children and women are incorporated in their programmes. The programme will also support activities to improve local-level urban planning and management through technical cooperation and training for municipalities and city development authorities, as well as community-level initiatives for urban improvement through community-based NGOs and local councils.

Programme support and management

51. In view of the decentralized pattern of government and public administration, UNICEF will continue to operate sub-offices in the four provinces, in addition to the country office, to assist the provincial governments in programme planning, implementation, monitoring and evaluation.

Evaluation

52. The programme will be monitored and reviewed jointly by the Government and UNICEF, both at the federal and the provincial levels, through a process combining regular reporting on performance and expenditures, annual reviews, specific evaluations and a mid-term review in the third year.

Cooperation with the United Nations and other organizations

53. The programme has been developed in close cooperation with the United Nations systems. UNDP and other concerned specialized agencies, including WHO, UNFPA, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the Food and Agriculture Organization of the United Nations (FAO), WFP, the International Labour Organisation (ILO) and the United Nations Development Fund for Women, as well as the World Bank and the Asian Development Bank (AsDB), have participated in the strategy formulation and programme elaboration stages of the programme preparation process. The programme has also been shared with bilateral agencies and NGOs working for children and women in Pakistan. Implementation of the programme will involve

close collaboration with concerned agencies of the United Nations system, the World Bank, AsDB and bilateral agencies and NGOs. UNICEF will seek to support the Government in its coordinating role for international assistance for children and women.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Pakistan (1990 and earlier years) UNICEF country classification

Under-five mortality rate	158	(1990)	Very high U5MR
Infant mortality rate	104	(1990)	Very high IMR
GNP per capita	$ 380	(1990)	Low GNP
Total population	122.6 Million	(1990)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	3136	4050	4958	5452
Infant deaths (under 1)	(thousands)	448	506	570	567
Under-five deaths	(thousands)	687	782	868	861
Under-five mortality rate (per 1,000 live births)		219	193	175	158
Infant mortality rate (under 1) (per 1,000 live births)		143	125	115	104

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1985-1987)	Moderate & severe	..	52[a]
	Severe	..	10[b]
Babies with low birth weight (%, 1976/1985)		11	25*
% of primary school children reaching final grade (1981)		..	49*

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1975/1988)		90/ 86/ 78	87*/ 74*/ 70*
Prevalence of wasting (%, 1980/1985-87)		14	17[c]
Prevalence of stunting (%, 1980/1985-87)		..	42[d]
Daily per capita calorie supply (% of requirements, 1979-1981/1988)		97	95
Food production per capita index (Index 1979-1981=100, 1980/1990)		99	105
Household expenditure (% of total income, 1980-1985)	All food/cereals		54 / 17

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1987)			42
Access to health services	Total	51	55
(% of population, 1980/1985)	Urban/rural	100/ 32	99/ 35
Access to safe water	Total	35	56
(% of population, 1980/1990)	Urban/rural	72/ 20	80/ 45
Access to adequate sanitation	Total	14	20
(% of population, 1980/1985)	Urban/rural	42/ 2	51/ 6
Births attended by trained personnel (%, 1976/1989)		24	40*
Maternal mortality rate (per 100,000 live births, 1984)		..	500

Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	11	41	87
	DPT	3	30	83
	Polio	3	30	83
	Measles	2	23	75
Pregnant women (%) immunized against	Tetanus	1	9	70

TABLE 1 (continued)

Pakistan

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	39/ ..	40/ ..
(%, 1980/1987)	Male	51/ ..	51/ ..
	Female	26/ ..	28/ ..
Secondary enrolment ratio (gross/net)	Total	14/ ..	19/ ..
(%, 1980/1987)	Male	20/ ..	26/ ..
	Female	8/ ..	11/ ..
Adult literacy rate, 15 years & older	Total	21	35
(%, 1970/1990)	Male/female	30/ 11	47/ 21
Radio/television sets			
(per 1,000 population, 1980/1988)		64/ 11	86/ 13

DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Million)	65.7	85.3	103.2	122.6	162.4
Population aged 0-15 years	(Million)	..	39.9	48.4	58.4	74.5
Population aged 0-4 years	(Million)	..	14.5	20.3	23.0	24.8
Urban population (% of total)		25	28	30	32	38
Life expectancy at birth	Total	48	53	55	58	63
(years)	Male	49	53	55	58	63
	Female	47	53	55	58	63
Total fertility rate		7.0	7.0	6.8	6.2	4.8
Crude birth rate (per 1,000 population)		48	49	49	44	34
Crude death rate (per 1,000 population)		19	15	14	12	8

		About 1980	Most recent
Contraceptive prevalence rate		3	8
(%, 1980/1984)			
Population annual growth rate	Total	3.1	3.6
(%, 1965-1980/1980-1990)	Urban	4.3	4.9

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		1.8	2.9
(%, 1965-1980/1980-1990)			
Inflation rate (%, 1965-1980/1980-1989)		10	7
Population in absolute poverty	Urban/rural	32/ 29	../ ..
(%, 1979)			
Household income share	Top 20%/bottom 40%	../ ..	../ ..
(%)			
Government expenditure	Health/education	2/ 3	1/ 3
(% of total expenditure, 1980/1987)	Defence	31	30
Household expenditure	Health/education		3/ 3
(% of total income, 1980-1985)			
Official development assistance:	US$ millions	1130	1119
(1980/1989)	As % of GNP	4	3
Debt service			
(% of goods & services exports, 1980/1989)		11	16

a/ Less than 80% median weight-for-age. b/ Less than 60% median weight-for-age.

c/ Less than 80% median; aged 13-24 months. d/ Less than 90% median; aged 25-60 months.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1988-1991

(In thousands of United States dollars)

COUNTRY: PAKISTAN
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $35,000,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	10889	4779	992	424	438	112	851	22	13170	5337	18507
Water supply and sanitation	6673	995	150	9	769	207	666	716	8258	1927	10185
Nutrition	1495	4	63		105		154		1817	4	1821
Education	459	79	251	16	211		364	55	1285	150	1435
Community organization and development	115	36	40		207		205		567	36	603
Women-centred programme	583	267	307	32	207	58	676	6	1773	363	2136
Children in especially difficult circumstances	37		24		88		133		282		282
Advocacy	348		52		165		286		851		851
Emergency		412		18		133		7		570	570
Planning and project support	466	11	13		5638		546	34	6663	45	6708
Freight	262	194					719		981	194	1175
GRAND TOTAL	21327	6777	1892	499	7828	510	4600	840	35646 a/	8625	44271

GR = General resources.
FSF = Funded supplementary funding.
a/ Including allocations to fund unfunded supplementary funding.

TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: PAKISTAN Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Health	GR	4500	4500	4300	4100	4050	21450
	NSF	1500	1710	1950	1900	1940	9000
Safe motherhood	GR	1000	1000	1000	1000	1000	5000
	FSF	1515	823				2338
	NSF	820	820	910	950	1000	4500
Nutrition	GR	1150	1100	1100	1100	1100	5550
Water and sanitation	GR	2500	2300	2300	2300	2300	11700
	FSF	1421					1421
	NSF	3150	3880	4550	5270	5650	22500
Education	GR	1800	2000	2000	2300	2300	10400
	FSF	337					337
	NSF	1800	1900	2100	2300	1900	10000
Women-centred programme	GR	900	900	900	800	800	4300
	NSF	200	500	600	800	900	3000
Children in especially difficult circumstances	GR	300	300	300	300	300	1500
	NSF	100	350	450	550	550	2000
Social mobilization and advocacy	GR	500	500	500	500	500	2500
Planning and social statistics	GR	150	200	250	250	250	1100
Programme support	GR	1200	1200	1350	1350	1400	6500
The urban unreached	GR	300	300	300	300	300	1500
	NSF		250	500	700	1050	2500
TOTAL	GR	14300 a/	14300	14300	14300	14300	71500
	FSF	3273	823				4096
	NSF	7570	9410	11060	12470	12990	53500
GRAND TOTAL		25143	24533	25360	26770	27290	129096

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.
a/ In addition, $677,600 was allocated prior to 1992 for unfunded supplementary funds.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: PAKISTAN	Number of posts	Amount (Thousands of United States dollars)
FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	4	1042
Local national Professional and General Service established posts	38	1168
Operating costs		1836
Total	42	4046
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	13	2400
Supplementary funds		
Local national Professional and General Service project posts		
General resources	95	2427
Supplementary funds	13	373
Total	121	5200

a/ For information source, see the 1992 revised post authorization table, dated 23 July 1991.

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UNITED NATIONS CHILDREN'S FUND
Programme Committee
1992 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION**

Pakistan

The Executive Director recommends that the Executive Board approve the country programme of Pakistan for the period 1992-1996 in the amount of $71.5 million from general resources, subject to the availability of funds, and $53.5 million in supplementary funds, subject to the availability of specific-purpose contributions.

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* Reissued for technical reasons.

** In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. Although Pakistan's economy is growing steadily, the country now has a heavy burden of debt servicing. Unemployment is high, and the workforce, much of which is employed in the informal sector, suffers from low levels of training and productivity. Social indicators reflect a general apathy in the past towards social sector development, which has not received its due share of funding. According to one estimate, 30 per cent of the population lives below the poverty line. The populations in larger cities are better off than those in rural areas and smaller towns, but unplanned urban growth has led to pockets of severe urban poverty.

2. Pakistan's population is now approximately 122.6 million and its growth rate of 3.6 per cent per year is one of the highest in the world, posing multiple threats to continued economic and social development. Family planning services have not yet had an impact. Data from 1984-1985 indicate that only 11 per cent of married women has ever used any contraceptive method. Population growth is related to the traditional family system and expectations for women to bear large numbers of male children. Such multiple, unspaced pregnancies, combined with poor maternal nutrition and underdeveloped maternity services, result in a high maternal mortality rate of at least 500 per 100,000 live births.

3. The same factors affect the health of infants and young children. Some 25 per cent of babies are of low birth weight. Infant and under-five mortality are approximately 104 and 158 per 1,000 live births, respectively. The major causes are neonatal tetanus, diarrhoea, acute respiratory infections (ARI) and measles. However, programmes to combat those threats are being implemented, and the expanded programme on immunization (EPI) has now immunized over 80 per cent of children under one year of age with all EPI antigens except measles, for which some 79 per cent of children under one year old have been reached. Although breast-feeding has remained the norm, breast milk is often improperly supplemented, and weaning often takes place too early and without the adequate supplementation of nutritious foods. As a result of those factors, and of sheer poverty, only 43 per cent of children nationwide are well-nourished. In addition to protein-energy malnutrition, there are serious problems of iron, iodine and vitamin A deficiencies. Pakistan also has a high rate of various childhood disabilities, without the highly developed services to treat, care for and rehabilitate those affected.

4. Pakistan has increasing environmental problems, including pollution, deforestation and waterlogging. The provision of clean water and proper sanitation is still inadequate, with only 45 per cent of the rural population having access to clean water and only 10 per cent to proper sanitation. Coverage is better in towns, but the lack of sanitation, drainage and proper solid waste disposal are among the many problems faced by dwellers in low-income urban settlements. However, experiments in the community-based provision of water and sanitation have been successful and are now receiving increased official support.

5. The traditional extended family is still strong. Where other family patterns are emerging, there is as yet insufficient attention to the material and psychological needs of young children. Organized preschool education is very rare.

6. The existing number of primary schools caters to only 63 per cent of children five to nine years of age. These schools often have poor physical facilities and too few teachers. There are also problems with the curriculum and management of primary education. The importance of education is still not sufficiently accepted by parents, particularly with regard to girls. The national adult literacy rate is only 31 per cent, and is far lower in rural areas.

7. There are an estimated 8 million working children, many of whom are driven by their families' poverty to work long hours in hazardous, unhealthy trades for pitiful wages. Work generally keeps them away from school, with a resulting loss to society as a whole. There are also children in other especially difficult circumstances, such as the small numbers exposed to bonded labour.

8. The problems faced by children in general are even more severe for girls. Some evidence, including Pakistan's exceptionally high overall ratio of males to females, suggests that unconscious neglect leads to greater mortality among girls. Prevailing norms restrict girls' access to health care, education and recreation, and may even seclude them inside the house. The primary school enrolment rate for girls is only 45 per cent, compared with 79 per cent for boys. The declaration of 1990 as the South Asian Association for Regional Cooperation (SAARC) Year of the Girl Child and the 1990s as the SAARC Decade of the Girl Child has begun to focus attention on those concerns.

9. Pakistan's cultural milieu supports a patriarchal family system in which women are socialized to be submissive and obedient. Women remain under the guardianship of men throughout their lives depending on their age and marital status, which probably has profound implications for women's development. Early marriage is still very common for girls, perpetuating the cycle of multiple pregnancies and poor health of mothers and children. Women work hard in the home and outside; their participation in the economy, especially in agriculture, is only beginning to be fully recognized and recorded. A significant and growing minority of women are now working in higher status jobs in the formal economy, but they still face obstacles, including a lack of training and educational facilities, a lack of child-care facilities and discrimination in the workplace and outside.

10. The situation of children and women is generally unfavourable, and worse than might be expected for a country in Pakistan's economic position. Nevertheless, the constitution and recent legislation and policy have all created an environment suitable for development in the sectors that will most benefit children and women. The main obstacle to such developments is the historic underfunding of the social sector, although there are arguably also problems in the government structures that plan and implement development

activities. Pakistan is a signatory to the World Summit Declaration and Plan of Action. The goals contained in that Plan of Action coincide closely with the goals contained in Pakistan's own national plans.

PROGRAMME COOPERATION, 1988-1991

11. The country programme for 1988-1992 has been reduced to four years because the annual programme budget levels were increased and the approved funds disbursed ahead of schedule.

12. A January 1991 Government/World Health Organization (WHO)/UNICEF evaluation of EPI indicated that Pakistan has reached over 80 per cent coverage for all childhood EPI antigens except measles. Special emphasis was placed on urban populations in which coverage had been shown to be lower than rural areas. A Federal Communications Advisory Group was established at the National Institute of Health as part of a major emphasis on programme communications. A sentinel surveillance system has been initiated for the EPI target diseases. Coverage of women of child-bearing age with tetanus toxoid increased from 27 per cent in 1987 to 32 per cent in 1989 and was estimated at 71 per cent by an international evaluation in early 1991. Female vaccinators and traditional birth attendants (TBAs) served to increase coverage of unprotected women.

13. The control of diarrhoeal diseases (CDD) programme emphasized training of health workers in correct case management of acute diarrhoea through the establishment of 10 diarrhoea training units. Standard treatment by private practitioners, paramedical workers and chemists has also been promoted. The work of the Federal Communications Advisory Group has created awareness among mothers regarding the availability of oral rehydration salt (ORS), although household surveys have shown that only approximately 20 per cent of mothers use ORS correctly. Efforts in this area have been coordinated with EPI, breast-feeding promotion, improved infant feeding practices, health education, water supply and sanitation activities and hygiene education.

14. The development of the national ARI control programme has been supported since 1989. Workshops with senior health administrators, academic paediatricians, decision makers and private paediatricians were held to identify programme objectives, develop national guidelines, plan programme implementation and prepare for the development of ARI training units at nine sites throughout the country.

15. In order to promote improved maternal and neonatal health, more than 40,000 new TBAs have been trained, and provincial monitoring and refresher training systems have been established. Operational research studies to strengthen the linkages between TBAs and local health facilities have been conducted. Child-spacing activities have been promoted by TBAs using motivation techniques. Pilot efforts to promote primary health care (PHC) were supported in the Islamabad Capital Territory and Sindh province. A pilot project for TBAs in Sindh provided a model for expanding the role of the TBA

to that of a PHC worker through further training in EPI, CDD, hygiene, malaria and child-spacing. In the area of health education, support has been provided to develop and produce training and communication materials and to strengthen provincial-level capacity.

Nutrition

16. Selected growth monitoring activities have been supported and nutrition education activities expanded through EPI staff and TBAs. There have been training activities for 400 medical officers, 200 lady health visitors (LHVs) and 18 TBAs. In collaboration with the Government/World Food Programme (WFP) supplementary nutrition programme, 700 medical officers and 2,200 LHVs have been trained at 1,600 outlets. Research studies to assess the nutritional status of hard-to-reach populations, develop an inventory of nutrition training programmes and review available information on vitamin A deficiency have been supported.

17. Breast-feeding steering committees have been formed to coordinate efforts to promote exclusive breast-feeding and healthy infant feeding practices. Selective operational research studies to assess trends in breast-feeding practices have been supported. Lactation management clinics have been established in a number of teaching hospitals, and the Ministry of Health has introduced a breast-feeding policy for hospitals and health centres along the lines of the "baby-friendly hospital" approach. Advocacy for the adoption of the International Code of Marketing of Breast Milk Substitutes continues at the policy level.

18. Both short- and long-term strategies are being supported for the national iodine deficiency disorders (IDD) control programme. Iodized oil capsules and injections have been provided for use in the highly endemic areas of northern Pakistan, as have training costs, logistical support and health education assistance. EPI staff in the North-West Frontier Provinces have been trained in IDD and are distributing capsules. Assistance has also been provided to expand the availability and use of iodized salt as the long-term strategy.

Water supply, environmental sanitation and hygiene education

19. An integrated package of water supply, household sanitation and personal hygiene at the community level in underserved areas has been the major thrust of the programme. Appropriate and low-cost technologies have been promoted, including the introduction of the "Afridev" model village-level operation and maintenance hand-pump in the lowlands and gravity-fed pipe systems in the mountainous areas. Starting from a demonstration phase in five districts, the programme has now expanded to 67 districts, with some 3,500 hand-pumps installed against the planned 6,000 and some 280 gravity-fed systems completed or under way against the planned 850 systems. The sanitation component promoted the household pour-flush or ventilated improved pit latrine model, but only about 8,000 of the planned 40,500 latrines were constructed. Efforts have started since 1991 to strengthen the training and hygiene education component of the programme, including the promotion of community participation

in the installation, operation and maintenance of water supply and sanitation facilities. Advocacy efforts have promoted the community-based, village-level operation and maintenance concept as a means to universalize water supply access, and the Government is now allocating more of its own resources to this strategy. To ensure sustainability, private sector manufacturers of the Afridev hand-pump have also been encouraged, with some 4,000 pumps per year now being entirely locally produced.

Education

20. A special focus was maintained on female education in all basic education activities. Support was extended to projects targeting females in rural and low-income urban areas, including the in-service and pre-service training of female teachers, outreach teacher training in Balochistan and the training of learning coordinators in the North-West Frontier Provinces. Supplies and equipment were provided to remote female primary schools in Jammu and Kashmir.* Non-formal primary education was supported through home schools, street schools and grass-roots non-governmental organizations (NGOs) in Sindh and the North-West Frontier Provinces. Integrated functional education was supported through Allama Iqbal Open University, Islamabad, and female literacy through NGOs in northern areas. After a delayed start, the primary education curriculum reform project picked up momentum in 1989-1991.

21. A number of advocacy efforts were supported before and as a follow-up to the World Conference on Education for All in 1990. Case-studies and situation analyses were made and seminars and workshops organized to disseminate information on the significance of basic education in overall national development. A task force in the Ministry of Education was supported to follow up Conference activities.

Women in development

22. Initiatives in this area aimed at mainstreaming gender concerns into sectoral planning and developing field approaches to increase options for education, health and economic participation. Such activities included documentation, advocacy, training, information dissemination and networking. Some success has been achieved in awareness creation, especially on the issue of the girl child and adolescent, information generation and sharing, and in-country and SAARC regional networking. Field programme action included strengthening integrated activities at existing women's centres, organizing female youth groups, vocational and micro-enterprise skill training, and facilitating access to credit. Outreach improved from about 100 locations in 1988 to some 500 project sites by 1991 against the targeted 1,000 locations.

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* The reference to Jammu and Kashmir does not imply the expression of any opinion whatsoever on the part of the secretariat of UNICEF regarding the legal status of the area or of its authorities or of the delineation of its frontiers or boundaries.

Constraints included the limited outreach capacity of NGOs; the inability of mid-level government and NGO field staff to work as catalysts, especially for group formation; a shortage of training facilities geared to specific needs of staff working with young girls; and inadequate counterpart funds for infrastructural costs.

Urban basic services

23. Based on experience gained from 1982 to 1987 in Lahore and Karachi, support was expanded to 34 low-income areas in six cities. Activities included EPI, literacy and non-formal education initiatives, sanitation and support to local government structures, including the recruitment of community organizers. The Orangi Pilot Project and the Municipal Training and Research Institute of the Ministry of Local Government were strengthened and have trained more than 150 community organizers, NGOs and government personnel since 1990. Linkages to major donor-aided projects in Sindh and Peshawar were initiated.

Childhood disability

24. The programme focused on enhancing awareness and promoting community-level services and capacity-building of government and NGOs. Innovative community-based projects were supported in three provinces, reaching some 600 disabled children and their families with home care support services. Low-cost rehabilitative technology was promoted in two provinces serving over 1,000 children. A pilot project that aimed at the identification and referral of primary schoolchildren with impairments was successfully launched in Karachi. Workshops and training courses on home and community services for over 200 workers were supported. A handbook on disabilities and other materials were produced for outreach workers.

Children in especially difficult circumstances

25. As a new area of collaboration, activities focused on research on children in especially difficult circumstances (CEDC) with studies covering child labour, children in prisons and orphanages and children under circumstances of pledged labour in the carpet and brick-making industries. Workshops at the provincial level and extensive media coverage have contributed to increased awareness. Some 15 NGOs are now involved in CEDC-related activities. Project activities included non-formal education for children working in the brick kiln in Punjab, community development in the North-West Frontier Provinces and three demonstration projects for working children in Karachi.

Planning, monitoring and evaluation

26. Improvement in programme planning, monitoring and evaluation was achieved through the identification of data gaps, streamlining project monitoring systems, specific research studies and third-party project evaluations. UNICEF has collaborated with the National Census Organization to generate more

gender-sensitive data from the 1991 census. The Statistics Division was supported to improve its knowledge of social indicators and to strengthen a district-based surveillance system to monitor the 1990s goals for children. In Sindh, a community-based surveillance system has been supported. UNICEF is assisting the Government to develop a national programme of action as a follow-up to the World Summit for Children. Support has also been extended for a study of adjustment with a human face as an input to the preparation of the Eighth Five-Year Plan.

Information, advocacy and social mobilization

27. Information and programme communication have been part of all UNICEF-supported programmes. Increased advocacy efforts have been targeted at various levels in Government and at NGOs, the community and other development agencies, and have particularly capitalized on the new opportunities created by the Convention on the Rights of the Child, the World Conference on Education for All, the SAARC Year of the Girl Child and the World Summit for Children. Children's issues appearing regularly in the press. Facts for Life has proved an effective tool for social mobilization of various groups in support of child survival and development programmes.

Lessons learned

28. A mid-term review in May 1990 provided the basis for adjustments in the country programme in 1990 and 1991 and for initiating the planning process for the 1992-1996 programme of cooperation. Among the lessons learned were: the importance of placing a particular focus on the unmet needs of the girl child as a beneficiary of social services; the need to strengthen the delivery of services through all sectors to low-income, unreached urban areas; the need to continue the focus on training of mid-level staff, with particular emphasis on supervisory functions; the importance of reinforcing efforts to promote community participation in all programmes; and the importance of continuing and taking further advocacy efforts to mobilize government and other partners towards a first call for children. In general, the mid-term review and other more specific evaluations endorsed the priorities and scope of UNICEF cooperation in Pakistan and recommended its continuation with some refocusing in the next cycle towards the goals for children in the 1990s.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

Recommended general resources: $71,500,000
Supplementary funding: $53,500,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Planning and monitoring	1 100	-	1 100
Advocacy and social mobilization	2 500	-	2 500
Child health	21 450	9 000	30 450
Safe motherhood	5 000	4 500	9 500
Nutrition	5 550	-	5 550
Education	10 400	10 000	20 400
Women in development	4 300	3 000	7 300
Water supply and sanitation	11 700	22 500	34 200
Children in especially difficult circumstances	1 500	2 000	3 500
Reaching the urban unreached	1 500	2 500	4 000
Programme support	6 500	-	6 500
Total	71 500	53 500	125 000

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects as shown in table 3.

29. The 1992-1996 programme of cooperation aims to advance the following national goals and objectives: (a) to place children's concerns high on the political and development agenda in the implementation of the World Summit Declaration and the Convention on the Rights of the Child; (b) to improve child survival by reducing infant and under-five mortality rates to 70 and 100 per 1,000 live births, respectively, by 1996; (c) to promote safe motherhood and to reduce maternal mortality to 300 per 100,000 live births by 1996; (d) to contribute to a reduction in population growth; (e) to expand coverage of water supply facilities from 55 to 65 per cent and sanitation facilities from 23 to 33 per cent and to eradicate dracunculiasis (guinea worm disease) by 1996; (f) to promote the social and intellectual development of children, particularly the girl child, through basic education; (g) to promote the integration of the disabled and socially disadvantaged, particularly working children in social services, especially basic education; and (h) to improve the situation of women and to enhance their status and role in the family, the

community and in national development. Particular emphasis will be placed on reaching remote rural areas and low-income urban areas.

Planning and monitoring

30. In support of the government commitment to the World Summit Plan of Action, the programme will assist the formulation and periodic updating of both the national and provincial programmes of action for children. The programme will also promote social action for children and women by facilitating a more systematic involvement of NGOs in the planning, implementation and monitoring of programmes for children. Training and technical assistance will also be supported. In order to track progress towards the goals for children in the 1990s, the programme will support the monitoring of basic indicators on children and women. The programme will seek to strengthen national and provincial capacities for collecting, analysing and publishing data on children, disaggregated by gender and by region, to ensure an equitable impact on girls and women and on other disparities. It will also seek to strengthen capacities for developing environment-friendly development policies, especially as they impact on children and women. Research of a qualitative nature on the situation of children and women will also be supported. Institutional networking with the United Nations Development Programme (UNDP) and the World Bank on human development will be pursued.

Advocacy and social mobilization

31. Advocacy and social mobilization will involve approximately 8 per cent of the resources planned for the five-year period. Advocacy for specific programme approaches and operational and technical options to improve the service delivery capacity for children and women are reflected in all sectoral programmes. The programme will also support a broad-based process of informing and involving strategically placed allies. The programme will seek to sensitize policy makers, legislators and community leaders about children's issues and to support the development and dissemination of information and communication materials in support of the programme objectives. Facts for Life will be used as a basic reference for advocacy messages on children and women.

Child health

32. The programme is based on targeted interventions to reduce childhood and maternal mortality while strengthening the health sector infrastructure necessary to develop a comprehensive PHC system. Specific focus will be placed on monitoring progress towards reaching the goals for children in the 1990s.

33. Emphasis will be placed on sustaining the achievements of universal child immunization, specifically on increasing tetanus toxoid coverage of women of child-bearing age, poliomyelitis eradication and reductions in measles morbidity and mortality. Strategies will be developed to identify and immunize socially and geographically disadvantaged populations in rural and

urban settings. Efforts will be made to reduce the dependency on outreach activities to deliver routine immunizations. Improved management systems for maintenance of the cold chain and transportation will be developed. Successful communications efforts will be expanded to promote complete immunization. Essential PHC interventions such as oral rehydration, the provision of iodized oil capsules and basic health education services will be delivered by EPI staff. Close collaboration with WHO, the United States Agency for International Development (USAID), the Canadian International Development Agency (CIDA), Rotary International and the World Bank will be continued.

34. The CDD programme will strengthen current activities to reduce mortality and morbidity from diarrhoeal diseases in children under five years of age. Although an estimated 80 per cent of mothers know about oral rehydration, additional emphasis is necessary to ensure that they know how to prepare and use ORS as well as to continue feeding during diarrhoeal episodes. ORS packets will be procured for training activities and demand-creation activities will be supported to increase ORS production by the private sector. CDD training for paramedical staff will be expanded and orientation workshops for private practitioners will be continued to improve their case management practices. Health education, breast-feeding promotion, nutrition education, safe water, sanitation and hygiene education activities will contribute to reductions in morbidity from diarrhoeal diseases.

35. Recent activities to establish a national programme for the control of ARI in children under five years of age will continue. Emphasis will be placed on expanding training of medical officers in case management, orienting private practitioners in new concepts of treatment, training health workers at clinic and first referral levels in case management, and drugs management. Operational research studies to clarify the clinical significance and extent of antibiotic resistance will be conducted and ethnographic studies will be supported to provide the data necessary to formulate a communications strategy.

36. Additional activities will include specific measures to improve the health education capacity of the provincial departments of health, support to model community health worker programmes, collaborative efforts to redesign and implement a simplified health information system for first-level care facilities, strengthened senior-level and mid-level management training and consideration of the development of a national field epidemiology training programme. Operational research activities will include support for the creation of a national research coordination mechanism, increased training in research methodology and funding of studies addressing selected essential national health research priorities.

Safe motherhood

37. Advocacy for safe motherhood, including discouraging early marriage and the preference for sons, will be emphasized. Existing provincial programmes to train TBAs will be expanded during the first two years through funding from CIDA. A revised curriculum will be utilized for the training of 30,000 new

TBAs. Mechanisms to provide refresher training for 24,000 TBAs annually, to create provincial and national databases of trained TBAs and to strengthen referral mechanisms for TBAs with local health facilities will be developed. The skills of LHVs to train and supervise TBAs will be upgraded. Studies will be supported to address priorities such as the referral of high-risk pregnancies and utilizing TBAs for the promotion of child-spacing.

38. Support will be provided to improve the quality of maternal and child health (MCH) care workers. Emphasis will be placed on upgrading the technical quality and clinical skills of antenatal care. Through collaboration with the World Bank Family Health Project, additional training, equipment and supervision will be provided to the current network of MCH centres.

39. New initiatives in support of the national population programme will be formulated. Collaboration will be maintained with other donors already involved in family planning such as the United Nations Population Fund (UNFPA), USAID, the World Bank, the United Kingdom Overseas Development Administration and CIDA. Advocacy and social mobilization for family planning and child-spacing activities will be key aspects of initial assistance. Support for the training of health department and NGO staff in counselling for family planning services will also be provided.

Nutrition

40. The programme will focus on extending the sites for nutrition education, expansion of targeted growth monitoring, improved coordination of nutrition surveillance and directed communications efforts. A nutrition curriculum for medical officers, LHVs and paramedical staff will be developed, pre-tested and integrated into other relevant child survival training activities. Community-based nutrition projects will be developed as models for initiating PHC programmes.

41. Support will continue to national and provincial breast-feeding steering committee activities, as will support for recently developed national breast-feeding policies for "baby-friendly" hospitals and health facilities. A national training course in lactation management will be developed to expand the national network of locations promoting breast-feeding to new mothers. Advocacy efforts will continue to encourage the Government to adopt the International Code of Marketing of Breast Milk Substitutes. TBAs will be utilized to improve breast-feeding and infant feeding practices. Applied research will be supported to identify the most effective approaches to increasing exclusive breast-feeding for at least four months and to identify healthy infant feeding practices that need reinforcement.

42. Support will continue for the national IDD control programme. Short-term activities to provide iodized oil through capsules or injections in the endemic target area of northern Pakistan will be supported by increased training, supply of commodities and transport, and further integration of IDD activities into EPI and schools. Expanded production of iodinated salt will be stimulated and increased communications activities will be promoted to

stimulate demand. Efforts to improve the surveillance and monitoring of programme activities will be essential for achieving national objectives. Intensified advocacy for legislation to mandate the iodination of salt will be promoted.

43. Iron and folate supplementation for pregnant and lactating females will be promoted. Targeted surveys to identify high-risk populations with vitamin A deficiency will be supported to plan nutrition education and supplementation activities. National guidelines regarding the indications for prophylactic use of vitamin A for selected indications will be promoted.

Basic education

44. Cooperation in this field will focus on improving educational opportunities for the girl child in particular, as well as for younger women. Support will focus on selected districts in three areas: improvement of primary education through formal and non-formal channels, with particular attention to the needs of girls and disadvantaged children, including working children and the disabled; promotion of female literacy with emphasis on functional approaches to reinforce other elements of child survival, protection and development; and advocacy in support of basic education, demand-creation and coordination with other agencies.

45. In formal primary education, the programme will focus on promoting female enrolment and reducing drop-outs. Working together with other partners, emphasis will be placed on improving the efficiency, effectiveness and relevance of the educational system. The primary education curriculum reform project will be continued, but with adjustments, taking into account the work of the World Bank and USAID in the same field. Strengthening of district-level management and female teacher training will be supported. Demonstration activities on the integration of disabled children in regular schools will continue to be supported, as will activities to detect impairments in schoolchildren. Non-formal approaches to primary education will be supported both at the policy level with Government and at the service delivery level through support to NGOs. The programme will support the improvement of the quality of learning in non-formal schools.

46. In view of the past lack of continuity in national literacy efforts, the programme will initially concentrate on supporting policy formulation, building the institutional basis for female literacy, including training of literacy teachers, and the development of literacy materials. Field-level activities will also be supported, particularly through NGOs. The programme will support awareness creation on basic education and literacy and promote research for the development of information and communication activities.

Women in development

47. The programme will focus on improved health and educational opportunities for girls and women, as well as activities to improve the economic status of disadvantaged rural and urban women and adolescents. It will provide for

field-level support through the Government and NGOs to non-formal education, to group formation for women and adolescents and to skills training and credit schemes to encourage employment and income-generation for low-income women. Field-level activities will aim to reach a minimum of 100,000 girls and women directly through 1,000 women's centres, 500 female youth groups and 100 credit groups. In line with the SAARC Decade of the Girl Child, the programme will promote research, training, advocacy and planning actions through government agencies, the media and NGOs to reduce the preference for male children and to ensure a more considered focus on the girl child in social sectoral planning and service delivery.

Water supply, environmental sanitation and hygiene education

48. The water supply, environmental sanitation and hygiene education programme will focus on advocacy through field-level action for the adoption of low-cost, appropriate technology, water supply and sanitation systems, combined with community involvement and training in systems installation, operation and maintenance and in hygiene education. The programme will support the installation of 20,000 hand-pumps for disadvantaged communities in rainfed lowland areas and 1,000 gravity-fed piped systems in mountainous areas. The few remaining pockets of dracunculiasis will be prioritized. The programme will also support the promotion of appropriate technologies and operational approaches for replicable household sanitation and hygiene education in rural communities and, as a new emphasis, in low-income urban areas. Support will be given to safe water supply, proper excreta disposal and improved hygiene standards in 11,000 primary schools, particularly for girls, to improve physical health conditions in these schools, to enhance enrolment and to complement the hygiene education elements of the classroom curriculum. The programme will also address improved sanitation and hygiene education in canal-irrigated areas. UNICEF and the Government will collaborate closely with other agencies in policy formation, advocacy, public information and monitoring and research for water supply, sanitation and hygiene education.

Children in especially difficult circumstances

49. The programme will address the needs of children whose circumstances preclude or inhibit their access to normal services and opportunities. This group includes children with disabilities, children below the age of 15 years who are working under exploitative or dangerous conditions, children in institutions and children subject to other forms of abuse or neglect. The programme will focus on advocacy to implement the relevant provisions of the Convention on the Rights of the Child and to create public awareness of the problems and needs of particularly disadvantaged children. For disabled children, support will be given to promoting ways of serving their needs through the mainstream of the health and education systems, and to strengthening parental and community awareness and actions. For working children, activities will be supported to improve their participation in basic education primarily through non-formal means. Efforts will be made to protect the child at the work place and to promote the abolition of child labour in

selected hazardous industries. For other categories of children in special circumstances, the programme will support advocacy, research and analysis and demonstration activities in selected institutions to minimize the worst effects of growing up outside a normal family environment. In addition to the leading role of the Government, the programme will seek to involve a wide range of NGOs and the private sector.

Reaching the urban unreached

50. Given the rapidly growing urban population and the increasing numbers of low-income settlements within cities that do not yet have adequate basic social services for children and women, the programme will promote the inclusion of unreached urban areas in the coverage of sectoral programmes, especially in relation to MCH care, basic education, opportunities for women and environmental sanitation. Building on the baseline data gathered during 1988-1991, the programme will focus on advocacy with other national and international agencies involved in urban development to ensure that the needs of unreached urban children and women are incorporated in their programmes. The programme will also support activities to improve local-level urban planning and management through technical cooperation and training for municipalities and city development authorities, as well as community-level initiatives for urban improvement through community-based NGOs and local councils.

Programme support and management

51. In view of the decentralized pattern of government and public administration, UNICEF will continue to operate sub-offices in the four provinces, in addition to the country office, to assist the provincial governments in programme planning, implementation, monitoring and evaluation.

Evaluation

52. The programme will be monitored and reviewed jointly by the Government and UNICEF, both at the federal and the provincial levels, through a process combining regular reporting on performance and expenditures, annual reviews, specific evaluations and a mid-term review in the third year.

Cooperation with the United Nations and other organizations

53. The programme has been developed in close cooperation with the United Nations systems. UNDP and other concerned specialized agencies, including WHO, UNFPA, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the Food and Agriculture Organization of the United Nations (FAO), WFP, the International Labour Organisation (ILO) and the United Nations Development Fund for Women, as well as the World Bank and the Asian Development Bank (AsDB), have participated in the strategy formulation and programme elaboration stages of the programme preparation process. The programme has also been shared with bilateral agencies and NGOs working for children and women in Pakistan. Implementation of the programme will involve

close collaboration with concerned agencies of the United Nations system, the World Bank, AsDB and bilateral agencies and NGOs. UNICEF will seek to support the Government in its coordinating role for international assistance for children and women.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Pakistan (1990 and earlier years) UNICEF country classification

Under-five mortality rate	158	(1990)	Very high U5MR
Infant mortality rate	104	(1990)	Very high IMR
GNP per capita	$ 380	(1990)	Low GNP
Total population	122.6 Million	(1990)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	3136	4050	4958	5452
Infant deaths (under 1)	(thousands)	448	506	570	567
Under-five deaths	(thousands)	687	782	868	861
Under-five mortality rate (per 1,000 live births)		219	193	175	158
Infant mortality rate (under 1) (per 1,000 live births)		143	125	115	104

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1985-1987)	Moderate & severe	..	52[a]
	Severe	..	10[b]
Babies with low birth weight (%, 1976/1985)		11	25*
% of primary school children reaching final grade (1981)		..	49*

NUTRITION INDICATORS	About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1975/1988)	90/ 86/ 78	87*/ 74*/ 70*
Prevalence of wasting (%, 1980/1985-87)	14	17[c]
Prevalence of stunting (%, 1980/1985-87)	..	42[d]
Daily per capita calorie supply (% of requirements, 1979-1981/1988)	97	95
Food production per capita index (Index 1979-1981=100, 1980/1990)	99	105
Household expenditure (% of total income, 1980-1985)	All food/cereals	54 / 17

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1987)			42
Access to health services	Total	51	55
(% of population, 1980/1985)	Urban/rural	100/ 32	99/ 35
Access to safe water	Total	35	56
(% of population, 1980/1990)	Urban/rural	72/ 20	80/ 45
Access to adequate sanitation	Total	14	20
(% of population, 1980/1985)	Urban/rural	42/ 2	51/ 6
Births attended by trained personnel (%, 1976/1989)		24	40*
Maternal mortality rate (per 100,000 live births, 1984)		..	500

Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	11	41	87
	DPT	3	30	83
	Polio	3	30	83
	Measles	2	23	75
Pregnant women (%) immunized against	Tetanus	1	9	70

TABLE 1 (continued)

Pakistan

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	39/ ..	40/ ..
(%, 1980/1987)	Male	51/ ..	51/ ..
	Female	26/ ..	28/ ..
Secondary enrolment ratio (gross/net)	Total	14/ ..	19/ ..
(%, 1980/1987)	Male	20/ ..	26/ ..
	Female	8/ ..	11/ ..
Adult literacy rate, 15 years & older	Total	21	35
(%, 1970/1990)	Male/female	30/ 11	47/ 21
Radio/television sets (per 1,000 population, 1980/1988)		64/ 11	86/ 13

DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Million)	65.7	85.3	103.2	122.6	162.4
Population aged 0-15 years	(Million)	..	39.9	48.4	58.4	74.5
Population aged 0-4 years	(Million)	..	14.5	20.3	23.0	24.8
Urban population (% of total)		25	28	30	32	38
Life expectancy at birth	Total	48	53	55	58	63
(years)	Male	49	53	55	58	63
	Female	47	53	55	58	63
Total fertility rate		7.0	7.0	6.8	6.2	4.8
Crude birth rate (per 1,000 population)		48	49	49	44	34
Crude death rate (per 1,000 population)		19	15	14	12	8

		About 1980	Most recent
Contraceptive prevalence rate (%, 1980/1984)		3	8
Population annual growth rate	Total	3.1	3.6
(%, 1965-1980/1980-1990)	Urban	4.3	4.9

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1990)		1.8	2.9
Inflation rate (%, 1965-1980/1980-1989)		10	7
Population in absolute poverty (%, 1979)	Urban/rural	32/ 29	../ ..
Household income share (%)	Top 20%/bottom 40%	../ ..	../ ..
Government expenditure	Health/education	2/ 3	1/ 3
(% of total expenditure, 1980/1987)	Defence	31	30
Household expenditure (% of total income, 1980-1985)	Health/education		3/ 3
Official development assistance:	US$ millions	1130	1119
(1980/1989)	As % of GNP	4	3
Debt service (% of goods & services exports, 1980/1989)		11	16

a/ Less than 80% median weight-for-age. b/ Less than 60% median weight-for-age.

c/ Less than 80% median; aged 13-24 months. d/ Less than 90% median; aged 25-60 months.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

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TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1988-1991

(In thousands of United States dollars)

COUNTRY: PAKISTAN
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $35,000,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	10889	4779	992	424	438	112	851	22	13170	5337	18507
Water supply and sanitation	6673	995	150	9	769	207	666	716	8258	1927	10185
Nutrition	1495	4	63		105		154		1817	4	1821
Education	459	79	251	16	211		364	55	1285	150	1435
Community organization and development	115	36	40		207		205		567	36	603
Women-centred programme	583	267	307	32	207	58	676	6	1773	363	2136
Children in especially difficult circumstances	37		24		88		133		282		282
Advocacy	348		52		165		286		851		851
Emergency		412		18		133		7		570	570
Planning and project support	466	11	13		5638		546	34	6663	45	6708
Freight	262	194					719		981	194	1175
GRAND TOTAL	21327	6777	1892	499	7828	510	4600	840	35646 a/	8625	44271

GR = General resources.
FSF = Funded supplementary funding.
a/ Including allocations to fund unfunded supplementary funding.

TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: PAKISTAN Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Health	GR	4500	4500	4300	4100	4050	21450
	NSF	1500	1710	1950	1900	1940	9000
Safe motherhood	GR	1000	1000	1000	1000	1000	5000
	FSF	1515	823				2338
	NSF	820	820	910	950	1000	4500
Nutrition	GR	1150	1100	1100	1100	1100	5550
Water and sanitation	GR	2500	2300	2300	2300	2300	11700
	FSF	1421					1421
	NSF	3150	3880	4550	5270	5650	22500
Education	GR	1800	2000	2000	2300	2300	10400
	FSF	337					337
	NSF	1800	1900	2100	2300	1900	10000
Women-centred programme	GR	900	900	900	800	800	4300
	NSF	200	500	600	800	900	3000
Children in especially difficult circumstances	GR	300	300	300	300	300	1500
	NSF	100	350	450	550	550	2000
Social mobilization and advocacy	GR	500	500	500	500	500	2500
Planning and social statistics	GR	150	200	250	250	250	1100
Programme support	GR	1200	1200	1350	1350	1400	6500
The urban unreached	GR	300	300	300	300	300	1500
	NSF		250	500	700	1050	2500
TOTAL	GR	14300 a/	14300	14300	14300	14300	71500
	FSF	3273	823				4096
	NSF	7570	9410	11060	12470	12990	53500
GRAND TOTAL		25143	24533	25360	26770	27290	129096

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.
a/ In addition, $677,600 was allocated prior to 1992 for unfunded supplementary funds.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: PAKISTAN	Number of posts	Amount (Thousands of United States dollars)
FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	4	1042
Local national Professional and General Service established posts	38	1168
Operating costs		1836
Total	42	4046
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	13	2400
Supplementary funds		
Local national Professional and General Service project posts		
General resources	95	2427
Supplementary funds	13	373
Total	121	5200

a/ For information source, see the 1992 revised post authorization table, dated 23 July 1991.